Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Dunn, a prisoner at HMP The Verne, on 31 March 2022

A report by the Prisons and Probation Ombudsman

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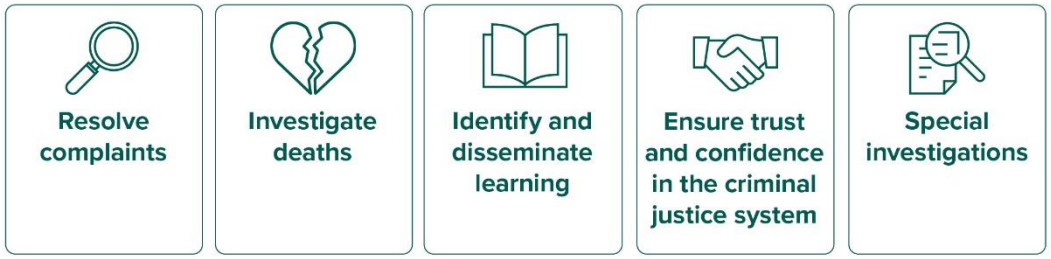
OUR VISION

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

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.

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, then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Gordon Dunn died in hospital of community acquired pneumonia caused by frailty of old age, on 31 March 2022, while a prisoner at HMP The Verne. He was 92 years old. I offer my condolences to his family and friends.

Mr Dunn had complex healthcare needs which were challenging to meet in a prison setting, and which certainly could not be met at The Verne. His death raises important questions for HMPPS about how best to meet the needs of prisoners who need 24 hour social care.

His Majesty's Inspectorate of Prisons and the Independent Monitoring Board noted that healthcare provision at The Verne was insufficient for the ageing population. It had taken too long for NHS commissioners to carry out a population health needs assessment. As a result, the health services team was under-resourced and was unable to meet the needs of the population.

The clinical reviewer concluded that the clinical care Mr Dunn received at The Verne was partly equivalent to what 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.

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

Contents

Summary

Events

1. On 21 November 2019, Mr Gordon Dunn was sentenced to eight years in prison for sexual offences. He was 90 years old. Mr Dunn spent time in several prisons and on 9 December 2019, he was transferred to HMP Dartmoor.

2. Mr Dunn had a long and complex medical history. From January 2022, his health deteriorated, and he needed more assistance with his care. Staff assessed him and decided that he should be supported under the Prison Service suicide and self-harm monitoring procedures (known as ACCT).

3. On 20 January 2022, Mr Dunn was transferred to HMP The Verne because staff at Dartmoor could not meet his care needs. The Verne does not have 24 hour healthcare provision.

4. On 9 March, prison staff moved Mr Dunn to the Care and Separation Unit (CSU) on medical grounds, pending his transfer to a more suitable prison. (The CSU is where prisoners are segregated away from the general prison population for their own safety or the safety of others or for breaking prison rules.) The next day, after concerns about Mr Dunn being located in the CSU, prison staff moved him to the care suite. This is a specially designated room for prisoners who may need frequent access to healthcare staff. Mr Dunn tested positive for COVID-19 and was placed in isolation.

5. On 24 March, due to his deteriorating health, a nurse arranged for an ambulance to take Mr Dunn to hospital for assessment. Hospital staff treated Mr Dunn for pneumonia and COVID-19.

6. On 31 March, all active treatment stopped, and hospital staff supported Mr Dunn with end of life care. That day, it was confirmed that Mr Dunn had died.

Findings

7. HMP The Verne was not equipped to manage Mr Dunn's complex care needs. With an increasing elderly prison population, HMPPS should consider how best to provide 24-hour care for prisoners who cannot be easily or quickly released.

8. The clinical reviewer concluded that Mr Dunn's clinical care at The Verne was partially equivalent to what he could have expected to receive in the community.

9. Healthcare staff did not monitor Mr Dunn's health using the NEWS2 tool (to detect acute illness and deterioration) as they should have done, which is not in line with NICE guidelines, and which is an issue we have repeatedly raised in our investigations.

Recommendations

- HMPPS, working in partnership with Ministry of Justice, ADASS, DHSC and NHS England, should explore options for developing a pathway for prisoners who have been assessed as needing residential social care to access an appropriate care setting. This work should be governed through the National Social Care Partnership Board.

- The Governors and Heads of Healthcare of HMP Dartmoor and HMP The Verne should ensure that they follow PSI 03/2016 when considering transfers for prisoners receiving local authority care and support.

- The Governor should share this report with the Director of Adult Social Services for Dorset

- The clinical regional manager of Oxleas NHS Trust should:

    - provide assurance to NHS England – Southwest in relation to the repeated recommendations made at HMP The Verne regarding use of the NEWS2 tool;

    - provide a timeframe and assurance on when the NEWS2 will be consistently used at HMP The Verne; and

    - the NHSW Commissioner should inform the PPO of the outcome within six months.

The Investigation Process

10. We were notified of Mr Dunn's death on 31 March 2022. The investigator issued notices to staff and prisoners at HMP The Verne informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

12. The investigator interviewed two members of staff and a prisoner on 30 May 2022, using Microsoft Teams.

13. NHS England commissioned an independent clinical reviewer to review Mr Dunn's clinical care at the prison. She conducted joint interviews with the investigator.

14. We informed HM Coroner for Dorset of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Dunn's daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond. However, the Coroner's officer contacted us to advise that Mr Dunn's family would like a copy of the initial report which we sent to them.

16. Mr Dunn's family received a copy of the initial report. They did not raise any issues, or comment on the factual accuracy of the report.

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

Background Information

HMP The Verne

18. The Verne holds up to 580 men convicted of sex offences. Prisoners live in dormitory style units. Each unit has its own common room and dining room.

19. Oxleas NHS Trust provides healthcare services at The Verne. The healthcare department is staffed daily between 7.30am and 6.00pm. Outside those hours prison staff call either the emergency services for an ambulance, or the NHS 111 telephone line for health advice, depending on the prisoner's need. There is no inpatient facility.

HM Inspectorate of Prisons

20. The most recent inspection of HMP The Verne was in February 2020. Inspectors reported that staff and prisoner relationships were some of the best they had seen. 97% of prisoners reported that most staff treated them with respect, 99% reported having a key worker and 86% of those said their key worker was helpful.

21. Inspectors noted that the healthcare provision was less positive. Over half of the prisoners at The Verne at the time of the inspection were aged over 50. However, it had taken too long for NHS commissioners to carry out a health needs assessment of the population. As a result, the health services team was under-resourced and was unable to meet the needs of the population.

Independent Monitoring Board

22. 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 July 2021, the IMB at The Verne reported that 15% of The Verne residents were over 70. Given the ageing population, healthcare needs were becoming more complex.

23. The IMB noticed an increase in the need for assessments for social care funded by the local authority and for places in care homes. The Board also noted that there needed to be better coordination between prison and healthcare staff to ensure a coordinated approach for the referrals.

24. The Board also said that due to the ageing population, more on-site care provision was necessary and should include fulltime qualified carers to remain at all times as this may avoid the need for hospitalisation, saving on the cost of staff on bed watches and disruption due to staff absences.

25. The Board noted that members routinely visited the Care and Separation Unit (CSU) during their rota visits. The CSU logs usually showed that daily visits were made by appropriate staff.

Previous deaths at HMP The Verne

26. Mr Dunn was the thirteenth prisoner to die at The Verne since August 2020. Of the previous deaths, 11 were from natural causes and one is awaiting classification. Since Mr Dunn's death, there have been four deaths from natural causes and one self-inflicted death.

27. In our previous investigations into the deaths of three prisoners at the Verne in 2021 and 2022, we made recommendations about the need to use the NEWS2 assessment tool. In January and November 2021, the Head of Healthcare accepted our recommendations and said that NEWS2 was used for every observation calculation as best practice. Pocket guide aide-memoires were being used from August 2020.

28. In July 2022, we recommended that the NHSE Commissioner for the South (Southwest) region write to the Ombudsman setting out what she was doing to satisfy herself that healthcare staff at The Verne were consistent in understanding and following national guidelines when using the NEWS assessment tool. The Commissioner responded and said that this was being managed at the quarterly Clinical Quality Review Meetings, and that she was satisfied with both the policy and implementation.

Assessment, Care in Custody and Teamwork

29. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

30. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

COVID-19 (coronavirus)

31. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

32. COVID-19 can make anyone seriously ill, but some people are clinically vulnerable to developing severe illness and complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who were symptomatic; and separate newly-arrived prisoners from the main population.)

Other measures included social distancing and the use of personal protective equipment (PPE).

33. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a Personal Management Plan, which is then facilitated by operational staff.

Key Events

34. On 21 November 2019, Mr Gordon Dunn was sentenced to eight years in prison for sexual offences and sent to HMP Winchester. He was 90 years old.

35. Mr Dunn had a complex medical history which included diagnoses of chronic prostatitis (inflammation of the prostate gland), hiatus hernia, gastro-oesophageal reflux disease (GORD), osteoarthritis, hypothyroidism, chronic kidney disease, heart failure, inflammation of the oesophagus, inflammation of the bile duct system, high blood pressure, hearing loss and frailty.

HMP Dartmoor

36. On 9 December 2019, Mr Dunn was transferred to HMP Dartmoor. Dorset Council provided a daily social care package to support him with his personal care (local authorities are responsible for providing social care to prisoners). However, from January 2022, his health deteriorated, and he developed problems with eating and he appeared confused.

37. On 9 January, staff started suicide and self-harm prevention measures (known as ACCT) as Mr Dunn was distressed about his deteriorating health. After speaking to him, the ACCT monitoring stopped. Staff re-started ACCT procedures later that day as a means to record staff welfare checks to ensure he had not fallen out of his bed. Once a risk management plan was created, staff agreed that ACCT procedures could be stopped. The post closure date was scheduled for 25 January 2022.

38. Healthcare staff noted that Dartmoor was not suitable for Mr Dunn in view of his age, medical conditions and mobility problems. Mr Dunn was also anxious about being located in a single cell and told staff he did not want to die alone. Healthcare staff made enquiries about transferring him to a more suitable prison. Dartmoor staff decided that The Verne might be a more suitable location for him because it had dormitory accommodation and might reduce his anxiety.

HMP The Verne

39. On 20 January, Mr Dunn was transferred to HMP The Verne. On arrival, staff contacted Dartmoor staff for an update on his condition. They noted that he was frail and had a social care package to help with daily tasks and that he had hearing problems.

40. Mr Dunn was located on a dormitory wing. Staff immediately arranged for him to have a hospital bed and a personal alarm.

41. On 22 January, Mr Dunn had a COVID-19 test and the result was negative.

42. On 26 January, staff stopped ACCT procedures which had been opened by staff at Dartmoor. The following day, staff organised an ACCT case review which was attended by a multi-disciplinary team (MDT) of prison staff and a range of healthcare staff. Healthcare staff created care plans and decided that Mr Dunn would have three night-time checks and a soft food diet. They appointed a prison buddy (a designated prisoner to assist him with his daily needs) and asked for an urgent local authority social care review.

43. On 1 and 5 February, Mr Dunn fell over several times. Healthcare staff reviewed him and noted that he had no injuries. They completed a falls risk assessment and identified that he was at high risk of falls.

44. On 9 February, the Head of Healthcare raised a safeguarding concern with prison managers as they were concerned that Mr Dunn's needs could not be met in prison. Mr Dunn's prison buddy told us that he had raised concerns about Mr Dunn almost daily and submitted a complaint to the Head of Healthcare, who responded and said that there were ongoing discussions about Mr Dunn's care.

45. On 11 February, the social care assessment concluded that Mr Dunn needed full time residential care and Dorset Council were exploring suitable residential care homes for him. In response to the safeguarding concern, the Governor and Head of Healthcare agreed that Mr Dunn would have a high calorie soft diet, adaptations to his dormitory to minimise his risk of falls and to put plans in place to move him to a residential care home.

46. On 14 February, Mr Dunn had another fall. He told healthcare staff that he was having negative thoughts. As a result, they completed a mental health referral. Mental health staff assessed him and noted that Mr Dunn was not orientated to time, place or person and his long and short term memory was poor. They recommended that he should be discharged from the mental health team and referred to memory services. Prison staff started a welfare log to record details about his care.

47. On 17 and 24 February, MDT meetings took place. They decided that a memory clinic referral was not needed but completed a referral to the NHS Care for the Elderly Service to address his frailty.

48. On 18 February, Mr Dunn said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

49. Mr Dunn had another fall on 21 February.

50. On 27 February, prison staff asked for a nurse to visit Mr Dunn as he was struggling to breathe. A nurse found that his respiratory rate was unstable and arranged for him to go to Dorset County Hospital. Two officers escorted him, and he was not restrained. Hospital staff diagnosed Mr Dunn with community acquired pneumonia and prescribed antibiotics.

51. Mr Dunn returned to The Verne on 28 February. On 1 March, a GP at the prison completed a review and noted that Mr Dunn should be monitored to complete his course of antibiotics and to ensure he did not deteriorate. However, Mr Dunn's health began to deteriorate from 3 March. Healthcare staff observed that his breathing seemed to halt for a few seconds, he appeared drowsy and had poor mobility. They did not always use the NEWS2 clinical assessment tool (to identify acutely unwell and deteriorating patients) as they should have done.

52. Mr Dunn had another fall on 9 March. He fell backwards onto a radiator, and staff found him on the floor. He had soiled himself but said he was not in pain. He had a cut on his leg and staff helped him into his wheelchair and helped him shower. Healthcare staff created a falls care plan.

Care and Separation Unit

53. At 5.30pm that day, a deputy governor authorised Mr Dunn's move to the Care and Separation Unit (CSU – where an individual is kept apart from other prisoners) on medical grounds and because prisoners in Mr Dunn's dormitory had complained that Mr Dunn had been keeping them awake during the night. The governor noted this was a temporary move while prison staff found a more suitable prison for him. Staff considered the CSU to be suitable as it was single cell accommodation.

54. Later that night at 10.00pm, prison staff noted in the welfare log that Mr Dunn was sitting in soiled clothing. No arrangements were in place for prison staff to deal with this because they were not allowed to clean him or request local authority social care assistance during the night. Prison staff recorded that that Mr Dunn had spent the night sitting on a bed with no clothing on the lower half of his body and with his head in his hands. The officer noted that this was not a decent way to treat Mr Dunn.

55. The next day, a nurse saw Mr Dunn in order to assess whether it was appropriate to hold him in the CSU. The nurse recorded that it was not appropriate for Mr Dunn to be housed in CSU, and that he would be more appropriately placed in the care suite as this was a single cell with in-cell sanitation, a kitchen area (with rounded sink edges for safety) and where staff could easily see him. A GP at the prison also reviewed Mr Dunn as part of the CSU assessment. The GP noted that Mr Dunn was agitated and presented with distrust of others, and that he thought he had done something wrong to be in the CSU. Mr Dunn would not allow the GP to assess him, and she arranged for him to be moved to the care suite quickly.

Care suite

56. At 2.00pm, prison staff moved Mr Dunn to the care suite. Healthcare staff helped him get into bed. Care staff checked him hourly until 11.30pm, and then checked him using an in-cell camera. A nurse noted that he appeared to be asleep.

57. At 4.15am on 11 March, Mr Dunn was sitting up in bed. A nurse went to check on him and he said that he was comfortable. At 6.30am, the nurse returned to the suite and helped him with his personal needs.

58. For the rest of the day, staff monitored Mr Dunn using the in-cell camera. Healthcare staff visited the suite to administer his medication and prison staff served him food. The rest of the time he was in the suite alone.

59. The next day, a prison officer set up a television and DVD player in the suite for Mr Dunn. The prison officer recorded in the welfare log that Mr Dunn had appeared confused but was able to walk short distances unaided. His only interaction was when prison staff checked on him and when healthcare staff came to administer his medication.

60. On 14 March, Mr Dunn told staff that he felt unwell. Staff tested him for COVID-19 and the result was positive. Staff monitored him using the in-cell cameras, as he began his COVID-19 isolation period.

61. On 16 March, the Clinical Team Leader raised a formal safeguarding concern with the prison safer custody team and the Governor. The safeguarding referral form detailed that Mr Dunn was isolating (due to COVID-19), he was behind a locked door of the care suite in the dark, and that there was no one supervising him to ensure meals and drinks were taken as he was being monitored by cameras only.

62. On 17 March, staff noted in the welfare log that there were no social care visits for Mr Dunn. Over the next few days, the welfare log noted that Mr Dunn was in long periods of isolation with minimal contact with staff. He remained in the care suite until 24 March. A healthcare assistant completed a routine check and noted that Mr Dunn was tired and confused and had leg sores which were oozing. She discussed his deteriorating condition with a nurse who arranged for an ambulance to take Mr Dunn to hospital.

63. Hospital staff treated Mr Dunn for pneumonia and COVID-19. On 31 March, active treatment stopped, and hospital staff supported him with end of life care. That day, Mr Dunn died in hospital.

Contact with Mr Dunn's family

64. The prison appointed a family liaison officer (FLO) to act on the prison's behalf as soon as Mr Dunn arrived at The Verne. The FLO contacted his daughter to update her about his transfer from Dartmoor. The FLO maintained contact with Mr Dunn's daughter and provided frequent updates.

65. After his death, the FLO contacted Mr Dunn's daughter to inform her of her father's death and provided further information and offered support over the following weeks.

66. The prison contributed to the costs of Mr Dunn's funeral, in line with national policy.

Support for prisoners and staff

67. After Mr Dunn's death, a prison manager debriefed the staff who were with Mr Dunn in hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Dunn'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 Dunn's death.

Cause of death

69. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Dunn's cause of death as community acquired pneumonia caused by frailty of old age. He also had chronic kidney disease and COVID-19 which contributed to but did not cause his death.

Findings

70. Mr Dunn was a very elderly man whose health and social care needs could not easily be met in prison. It is clear, however, that prison and healthcare staff at The Verne were both moved and troubled by Mr Dunn's condition and the limitations on the care they could provide him in prison.

Care pathway

71. From January 2022, Mr Dunn had increasing care needs and staff at Dartmoor and The Verne noted that they had difficulties meeting his social care needs. The local authority indicated that they would seek alternative residential care for him, but this had not happened by the time he died.

72. Mr Dunn's release options were limited to the use of a bedwatch (when prison officers supervise a prisoner in hospital for extended periods) or an application for compassionate release. At the time of Mr Dunn's deteriorating health, the policy setting out how prisoners can be released on compassionate grounds (known as early release on compassionate grounds (ERCG)) was in Prison Service Order (PSO) 6000. The four tests for an application were:

    - the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
    - the risk of re-offending is past; and
    - there are adequate arrangements for the prisoner's care and treatment outside prison; and
    - early release will bring some significant benefit to the prisoner or his/her family.

73. All requests for ERCG are made to the Public Protection Casework Section (PPCS) of the Ministry of Justice who consider applications on behalf of the Secretary of State for Justice. The PPCS require details of the condition and prognosis, and any planned treatment for the prisoner. There must be evidence from a medical specialist (usually a consultant).

74. Mr Dunn did not have a terminal illness and he was not bedridden or similarly incapacitated. However, he was dependent on others for basic tasks, had difficulties moving around safely and his needs could not be met in prison. We note that in May 2022, the ERCG policy was updated with guidance on release for social care. This is a positive step which might have helped alleviate the issues that Mr Dunn faced.

75. With an increasing elderly prison population, HMPPS and partners, such as the Association of Directors of Adult Social Services (ADASS), Department for Health and Social Care (DHSC) and NHS England, should consider how best to meet the needs of prisoners who, if they were in the community, would qualify for residential care home provision. The issue of disparity in providing social care within a prison setting has been previously set out in the HM Inspectorate of Prisons' 2018

thematic report of social care in prisons. This issue goes beyond a single case in a single prison. We recommend:

HMPPS, working in partnership with Ministry of Justice, ADASS, DHSC and NHS England, should explore options for developing a pathway for prisoners who have been assessed as needing residential social care to access an appropriate care setting. This work should be governed through the National Social Care Partnership Board.

The decision to transfer Mr Dunn to The Verne

76. Prison Service Instruction (PSI) 03/2016 on adult social care sets out that local authorities are responsible for the continuity of care for prisoners receiving care and support. Where a prisoner receiving local authority care moves between prisons, the 'sending' local authority already providing care should liaise with the 'receiving' local authority to ensure continuity of care. The policy makes clear that prisons must inform local authorities of their plans to move prisoners.

77. Mr Dunn's move from Dartmoor to The Verne was arranged directly between the two prisons which are in different local authority areas (Devon and Dorset respectively). The move was apparently made on the basis that Mr Dunn did not want to be alone in a single cell and The Verne had dormitory style accommodation. However, The Verne did not have 24-hour healthcare cover and was not able to meet Mr Dunn's social care needs. Colleagues in the HMPPS Health and Social Care Team told us that the two prisons, two local authorities and the two healthcare providers should have planned for Mr Dunn's transfer before it took place so there was no disruption to his care. Partnership working at this stage could have explored whether The Verne was an appropriate location for a man with his level of need. It is not clear that conversations of this nature between the various providers took place before Mr Dunn moved. We make the following recommendation:

The Governors and Heads of Healthcare of HMP Dartmoor and HMP The Verne should ensure that they follow PSI 03/2016 when considering transfers for prisoners receiving local authority care and support.

78. There is important learning for The Verne and local partners who are outside our remit. We make the following recommendation:

The Governor should share this report with the Director of Adult Social Services for Dorset.

Clinical Findings

79. The clinical reviewer concluded that Mr Dunn's clinical care at The Verne was only partly equivalent to that which he could have expected to receive in the community. She found that there were examples of good practice and continued efforts to try and obtain the right care for Mr Dunn. However, there were areas that did not meet the expected standards. These included the need for improved clinical practice mainly around the use of the NEWS2 tool, COVID-19 management and onward clinical escalation. Full details of the clinical reviewer's findings are in the clinical review report. She made a number of recommendations which were not related to

Mr Dunn's death, but which the Head of Healthcare at The Verne will need to address.

NEWS2 scores

80. NEWS2 (National Early Warning Score), is a nationally recognised tool used to detect the deterioration and severity of a patient's condition. Healthcare staff at The Verne did not consistently use NEWS2 to check Mr Dunn's clinical observations or act upon them as they should have done. There were also omissions and delays in escalating clinical risk to an appropriate medical professional, and occasions where no clinical observations were recorded.

81. This is the fourth investigation where we have made a recommendation about the use of NEWS2 scores at The Verne. In July 2022, the NHSE Commissioner for the South (Southwest) region told us that:

> "NHSE lead has seen and reviewed the healthcare provider's policy on NEWS 2 and its use in prison settings, not all of which have 24 hour provision. The use and the rollout of the policy has been discussed at the quarterly Clinical Quality Review Meeting (May 2022). The Commissioner has seen evidence of engagement in the policy by Practice Plus Group (PPG), the healthcare provider, and is satisfied with both the policy and the work done to implement it. Whilst NEWS 2 has not been adapted for use in prisons where repeated NEWS2 scoring is not possible out of hours, PPG have provided assurance that an escalation process is in place, and a handover to prison staff where there may be concerns. It is also clear that NEWS 2 is being successfully implemented across other healthcare providers in prison across the entirety of the Southwest region."

82. Despite assurances from the Commissioners, Mr Dunn's case has again highlighted the need for urgent improvement around the use of NEWS2 scores. We asked the Health & Justice Commissioning Team, NHS England - Southwest for an update. A representative said that Oxleas NHS Trust is now the healthcare provider at The Verne. She suggested that the clinical regional manager undertake an exercise to review the training and competency of staff with regard to NEWS2. She added that Oxleas has a clinical quality assurance team who could undertake a regular audit to identify areas for improvement. Within the team there is also a QI lead who could support a project looking at NEWS2 compliance.

83. We recommend:

The clinical regional manager of Oxleas NHS Trust should:

- **provide assurance to NHS England – Southwest in relation to the repeated recommendations made at HMP The Verne regarding use of the NEWS2 tool;**
- **provide a timeframe and assurance on when the NEWS2 will be consistently used at HMP The Verne; and**
- **the NHS England – Southwest Commissioner should inform the PPO of the outcome within six months.**

Governor and Head of Healthcare to note:

Falls management at HMP The Verne

84. Mr Dunn had numerous falls beginning in February 2022, but a falls care plan was only created on 9 March. This is not in line with National Institute for Health and Care Excellence (NICE) guidance. We bring this to the Head of Healthcare's attention.

Mr Dunn's location

85. Mr Dunn was transferred to the CSU at The Verne on 9 March. However, staff were less able to support him, particularly at night, the cell could not accommodate his hospital bed, he had no contact with his allocated buddy and Mr Dunn was confused and distressed by the decision. It was not the appropriate location for him and fortunately, he moved to the care suite the following day.

86. After Mr Dunn tested positive for COVID-19, he was isolated in the care suite with very limited human interaction.

87. Clearly, the prison had to make difficult decisions with limited options. However, the evidence suggests that neither the CSU nor the care suite were suitable locations for a man with Mr Dunn's needs. The Governor and Head of Healthcare will wish to consider the learning from this investigation to inform future planning.

Healthcare input into the escort risk assessment

88. Mr Dunn was not restrained when healthcare staff arranged for him to go to hospital on 24 March. However, the medical section of the risk assessment form was poorly completed, with too much incorrect or missing information (including the medical conditions that meant the use of restraints was not appropriate, and that Mr Dunn had tested positive for COVID-19). We bring this to the Head of Healthcare's attention.

Inquest

89. The inquest, held on 30 July 2024, concluded that Mr Dunn died from natural causes.

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Independent Investigations

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