Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Saunders, a prisoner at HMP Peterborough, on 1 January 2023

A report by the Prisons and Probation Ombudsman

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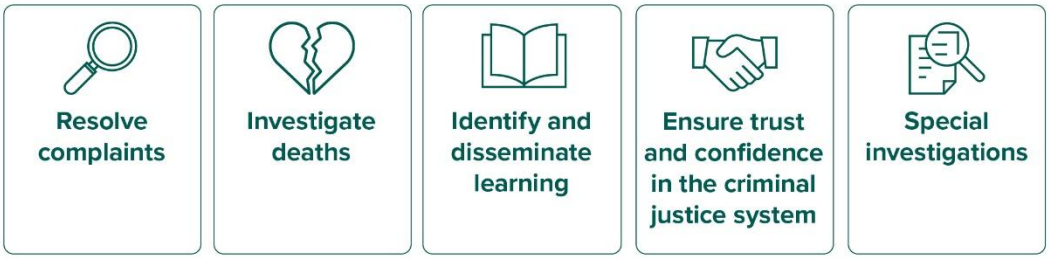
OUR VISION

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 HMPPS in ensuring the standard of care received by those within service remit if appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Keith Saunders died of infective exacerbation of COPD and ischaemic heart disease on 1 January 2023 at HMP Peterborough. He was 75 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare Mr Saunders received at Peterborough was partially equivalent to that which he could have expected to receive in the community.

She was concerned that the care plans created to manage Mr Saunders' COPD and asthma were not reviewed until two years after his arrival at Peterborough. She was also concerned that in the days leading up to Mr Saunders' death his NEWS2 score (National Early Warning Score) and oxygen saturation levels were not regularly recorded, and that Mr Saunders was not referred to a GP for urgent review when his NEWS2 score indicated that his health had deteriorated.

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 **July 2023**

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Summary

Events

1. On 12 September 1995, Mr Keith Saunders was charged with the manslaughter. He was sent to HMP Maidstone.

2. Mr Saunders had several pre-existing medical conditions, including asthma and COPD (chronic obstructive pulmonary disease, the name given to a range of respiratory conditions), chest pain and hypertension (raised blood pressure).

3. Mr Saunders was released from prison and was recalled on two occasions for breaching his licence conditions. He was last recalled to prison on 29 June 2016 and was sent to Peterborough prison.

3. A prison nurse carried out an initial health screen and noted his previous medical conditions. She also noted that he had limited mobility and used a wheelchair and a walking stick to move around. Healthcare staff created care plans to manage his care, and he was referred to the prison's older prisoner and long-term conditions clinics.

4. While at Peterborough, Mr Saunders was admitted to hospital on several occasions for exacerbation of COPD, an irregular heart rate and hospital acquired pneumonia.

5. At 3.30pm on 1 January 2023, a prisoner approached a Prison Custody Officer (PCO) and told him that he had seen Mr Saunders lying on the floor of his cell, and that he appeared extremely unwell. The PCO went to the cell immediately. He called Mr Saunders' name, but he did not respond. The PCO radioed a medical emergency code and staff in the prison control room telephoned for an emergency ambulance immediately.

6. More staff arrived at Mr Saunders' cell, and they started cardiopulmonary resuscitation (CPR) while they waited for the arrival of paramedics. At 3.38pm, the paramedics arrived and took over Mr Saunders' care and treatment. At 4.19pm, they confirmed that Mr Saunders had died.

7. The post-mortem report gave Mr Saunders' cause of death as infective exacerbation of COPD and ischaemic heart disease.

Findings

8. The clinical reviewer concluded that the healthcare Mr Saunders received at Peterborough was partially equivalent to that which he could have expected to receive in the community.

9. She found that the care plans created to manage Mr Saunders' COPD and asthma were not reviewed until two years after he arrived at Peterborough. In the days leading up to Mr Saunders' death his NEWS2 score (National Early Warning Score) and oxygen saturation levels were not recorded regularly, and a nurse did not refer Mr Saunders to a GP for further review as she should have done.

Recommendations

- The Head of Healthcare should review the pathway for long-term conditions to ensure compliance with NICE clinical guidance.

- The Head of Healthcare should ensure:

    - healthcare staff routinely record the NEWS 2 score when completing clinical observations on acutely unwell patients, to aid the prompt and timely recognition of deterioration; and

    - NEWS2 threshold triggers are adhered to across the service as per NICE MIB205 (Medtech innovation briefing 205)

The Investigation Process

10. HM Prison and Probation Service notified us of Mr Saunders' death on 1 January 2023. The investigator issued notices to staff and prisoners at HMP Peterborough 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 Saunders' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Saunders' clinical care at the prison.

13. We informed the Coroner for Cambridgeshire and Peterborough of the investigation who gave us the results of the 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 did not find any factual inaccuracies.

15. The Ombudsman's family liaison officer wrote to Mr Saunders' next of kin, his friend, to explain the investigation and to ask if he had any issues he wished the investigation to consider. He did not respond to her letter.

Background Information

HMP Peterborough

16. HMP/YOI Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons (HMIP)

17. The most recent inspection of HMP Peterborough was in November 2018. Inspectors reported that Peterborough had maintained strong clinical leadership and adequate staffing levels despite some challenges. They found that several aspects of health care provision had improved following the last inspection. Inspectors reported that the healthcare unit had a more clinical focus with prisoners placed there for clinical rather than operational reasons and found that clear care plans were in place.

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 March 2022, the IMB reported that clinical, mental health and drug services were not providing an adequate service. They noted that the steps needed to contain and the risk of the spread of COVID-19, had put additional pressure on the prison's healthcare staff and that against a backdrop of change healthcare staff did their best to provide the full range of services required.

19. The IMB also noted that many prisoners continued to report that they were dissatisfied with the healthcare services the prison provided. To ensure that healthcare standards were maintained and improved, the IMB said that Peterborough should prioritise reviewing and monitoring healthcare related complaints.

Previous deaths at HMP Peterborough

20. Mr Saunders was the fourteenth prisoner to die at Peterborough since January 2020. Of the previous deaths, nine were from natural causes, two were self-inflicted and two were drug related. There have been three further deaths since Mr Saunders' death two were from natural causes and one awaiting classification. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

21. On 12 September 1995, Mr Keith Saunders was charged with the manslaughter of his wife. He was sent to HMP Maidstone.

22. Mr Saunders had several pre-existing medical conditions, including asthma, COPD, chest pain and raised blood pressure.

23. On 1 June, Mr Saunders was released on licence. He was recalled to prison in October 2008, for breaching the conditions of his licence. Over the years that followed, he transferred between establishments on a number of occasions, until he was re-released in April 2016. However, a few months later, he was recalled to prison for breaching his licence conditions, and he was sent to Peterborough.

HMP Peterborough

24. A nurse completed an initial health screen. She noted Mr Saunders' medical conditions and also that he had mobility issues and used a wheelchair and a walking stick to move around. The nurse considered that due to his poor physical condition, he would benefit from being admitted to the prison's healthcare inpatient unit for closer observation. Mr Saunders refused and signed a disclaimer to that effect. The nurse created care plans to manage his conditions. Over the years that followed, healthcare staff and secondary care providers reviewed Mr Saunders regularly. He was admitted to hospital on several occasions to receive treatment for exacerbation of his COPD.

25. In 2021, Mr Saunders was taken to hospital and admitted as an inpatient on three occasions to receive treatment for a hernia (a condition in which part of the stomach squeezes up into the chest through an opening in the diaphragm), exacerbation of COPD, a lower respiratory tract infection, hypomagnesemia (a low serum magnesium level, often an indicator of chronic disease), and a fractured hip. Prison healthcare staff continued to review him regularly.

2022

26. On 6 May 2022, a nurse saw Mr Saunders after prison officers were concerned that he appeared confused and disorientated. She considered that he needed to be reviewed at hospital and he was taken to Peterborough City Hospital by emergency ambulance. Hospital staff diagnosed him with a chest infection and an erratic heart rate. He was admitted to hospital as an inpatient and treated with intravenous antibiotics and oxygen therapy. His condition improved and he was discharged back to the prison on 12 May.

27. On 12 July, a GP at the prison saw Mr Saunders. He noted that Mr Saunders appeared extremely unwell and that his breathing appeared laboured. He considered he might have developed pneumonia and sent him to hospital by emergency ambulance. Hospital staff diagnosed him with hospital acquired pneumonia. He was admitted as an inpatient and treated with intravenous antibiotics. He was discharged back to the prison on 20 July. Healthcare staff reviewed him regularly over the months that followed.

28. On 9 December, a nurse saw Mr Saunders after he complained of experiencing flu like symptoms. She took a note of his observations, which were within a normal range. Due to his recent bout of pneumonia, she suggested that he moved to the healthcare inpatient unit for closer observation. Despite repeated encouragement, he consistently refused. He was prescribed a course of antibiotics and told to rest. She reviewed him again later that afternoon and noted that his condition had improved.

29. On 24 December, a nurse attempted to review Mr Saunders after he complained of chest pain. Before she could do so, he told her that he wanted nothing to do with healthcare and that he would call for assistance if he needed it. The following day, a nurse saw Mr Saunders and encouraged him to take his medications, but he refused. She took a note of his observations and considered that he might have developed sepsis. She telephoned for an emergency ambulance and was told that the waiting time would be two and a half hours. When paramedics arrived at the prison, they diagnosed Mr Saunders with a chest infection and considered he would benefit from admission to hospital for closer observation. However, despite repeated encouragement, Mr Saunders refused to go. Paramedics asked that he be prescribed antibiotics. Two days later, a nurse saw him again and noted that his condition had improved and that he was taking his medications.

30. Later that day, a nurse also saw Mr Saunders. She noted his respiratory rate and blood pressure were within a normal range, but that his temperature was raised and that his oxygen saturation level was low. She made a note in his medical records and asked for a nurse on night duty to carry out a further review. Another nurse saw Mr Saunders in the early hours of the following morning. She noted his observations, which were within a normal range. She did not record his oxygen saturation level, or make a note of his NEWS2 score, despite his oxygen saturation level being recorded as low the previous day.

31. On 30 December, a nurse took a note of Mr Saunders' observations. She noted they were all within range except for his oxygen saturation level, which was low. She recorded his NEWS2 score as three. (A score of three requires an urgent review by a GP to consider if an escalation of clinical care or review by hospital staff is necessary.) There is no recorded evidence in his medical record to indicate that she referred him to a prison GP for urgent review.

32. The following day, a nurse saw Mr Saunders. He told her that he was experiencing a shortness of breath, which had not improved when he used his inhaler. She noted that Mr Saunders did not appear to have a cough and that he was able to speak in full sentences. She told him that she would review him again, but that he should ask for assistance should he feel the need. At 9.56am the following morning, she reviewed him again and noted that his condition had improved. She took a note of his observations, which she recorded as within a normal range.

Events of 1 January 2023

33. At 3.30pm on 1 January 2023, a prisoner approached PCO A and told him that he had seen Mr Saunders lying on the floor of his cell and that he appeared extremely unwell. The PCO immediately attended the cell. He called Mr Saunders' name, but he did not respond. He radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Staff in the prison control room telephoned for an emergency ambulance immediately.

34. PCO B responded to the code blue. When he arrived at the cell, he assisted PCO A to turn Mr Saunders onto his back and to check for signs of life, but there were none. They noticed blood on the floor, but it was not clear where the blood had come from. PCO B radioed a code red (indicating a prisoner is bleeding). Another PCO arrived shortly afterwards and cleared the landing outside of Mr Saunders' cell.

35. A nurse arrived shortly afterwards, accompanied by two more nurses, who brought an emergency grab bag. They moved Mr Saunders out of his cell and began CPR. The nurse attached a defibrillator to Mr Saunders' chest, but no shockable rhythm was found. He then inserted a cannula into Mr Saunders' wrist and an i-gel into his airway (a device used to open the airway to aid resuscitation).

36. At 3.38pm, the paramedics arrived at the cell and took over Mr Saunders' care and treatment. At 4.19pm, a paramedic confirmed that Mr Saunders had died.

Contact with Mr Saunders' family

37. On 1 January 2023, the prison appointed a Family Liaison Officer (FLO). He attempted to contact Mr Saunders' daughter to inform her of her father's death. However, the telephone number listed on Mr Saunders' prison records was incorrect. He then telephoned Mr Saunders' brother to ask if he had an up-to-date telephone number for Mr Saunders' daughter. He did not but said that Mr Saunders also had a son who may have had her current telephone number, and that he would try and contact him.

38. On 3 January, the FLO telephoned Mr Saunders' friend, who he had listed as his next of kin. He informed him of Mr Saunders' death and offered his support. Two days later, the FLO telephoned Mr Saunders' brother to ask if he had managed to obtain a number for Mr Saunders' daughter. He told the FLO that Mr Saunders' son did not have any contact details for his sister. He informed him of his brothers' death and offered him support. The FLO remained in contact with Mr Saunders' brother offering him support.

39. The prison contributed towards the cost of his funeral in line with national guidance.

Support for prisoners and staff

40. After Mr Saunders' death, welfare checks were offered to the staff involved in the emergency response. There is no evidence that managers held a post-incident debrief.

41. The prison posted notices informing other prisoners of Mr Saunders' 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 his death.

Post-mortem report

42. The post-mortem report gave Mr Saunders' cause of death as infective exacerbation of COPD and ischaemic heart disease.

Findings

Clinical care

43. The clinical reviewer concluded that the care Mr Saunders received at HMP Peterborough was only partially equivalent to that which he could have expected to receive in the community.

44. She did note, however, that healthcare staff managed Mr Saunders with a high level of compassion and care, even though he sometimes displayed challenging and difficult behaviour.

Care plans

45. The clinical reviewer noted that when Mr Saunders arrived at Peterborough, healthcare staff recorded that he had care plans in place to manage his COPD and asthma. However, she found that those care plans were not updated until two years after he arrived at the prison, contrary to NICE guidance NG80. She considered that the two-year gap between reviewing his care plans could have had a negative effect on the long-term management of his care. We recommend:

    The Head of Healthcare should review the pathway for long-term conditions to ensure compliance with NICE clinical guidance.

Use of NEWS2 scores

46. On 27 December, a nurse saw Mr Saunders and noted his observations, which she recorded as all being within a normal range. However, she did not record his oxygen saturation level, nor did she make a note of his NEWS2 score, despite his oxygen saturation level being recorded as low and of concern the previous day. Also on 30 December, a nurse did not refer Mr Saunders to a GP for review. She should have done after his NEWS 2 score indicated that he should be seen urgently. This was a missed opportunity to identify the extent to which Mr Saunders' health was deteriorating. We recommend:

    The Head of Healthcare should ensure

    - **healthcare staff routinely record the NEWS 2 score when completing clinical observations on acutely unwell patients, to aid the prompt and timely recognition of deterioration; and**

    - **NEWS2 threshold triggers are adhered to across the service as per NICE MIB205 (Medtech innovation briefing 205)**

47. The clinical reviewer made recommendations about record keeping, which we do not repeat in this report, but which the Head of Healthcare will need to address.

Inquest

At the inquest held on 29 February 2024, the coroner concluded Mr Saunders died of natural causes.

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