Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Snary, a prisoner at HMP The Verne, on 7 October 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Richard Snary died in Dorset County Hospital on 7 October 2020 of a heart attack while a prisoner at HMP The Verne. Mr Snary was 84 years old. I offer my condolences to Mr Snary's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Snary received at The Verne was of a good standard and equivalent to that which he could have expected to receive in the community. He made one recommendation.

5. We found no non-clinical issues of concern. We make no recommendations.

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

Recommendation

- **The Head of Healthcare should ensure that care plans are created for all prisoners with significant medical conditions which should be reviewed and updated regularly.**

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Snary's clinical care at The Verne.

8. The PPO investigator has investigated non-clinical issues, including Mr Snary's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Snary's next of kin, his grandson, to explain the investigation. He did not respond to our letter.

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

Previous deaths at HMP The Verne

11. Mr Snary was the third prisoner to die at The Verne since October 2018. The previous two deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Snary's death and our investigation findings for the previous deaths.

Key Events

12. In June 2014, Mr Richard Snary was convicted of sexual offences and sentenced to life imprisonment. He transferred to HMP The Verne on 6 August 2019.

13. Prior to his prison sentence, Mr Snary had a heart attack in 1993, a stroke in 2012 and had heart disease. He also had Type 2 diabetes, high blood pressure, chronic kidney disease, asthma, a hernia, impaired vison and hearing and reduced mobility (he used walking sticks and a wheelchair). Mr Snary had a coronary heart disease care plan in place on his arrival at The Verne to monitor his ischaemic heart disease.

14. Healthcare staff continued to monitor Mr Snary's heart conditions and appropriately issued his medication. They also ensured that he attended his hospital cardiology appointments. However, healthcare staff did not schedule regular appointments to review Mr Snary's cardiac care plan.

15. In December 2019, Mr Snary complained of bleeding from his penis. Healthcare staff referred him to hospital. Test results showed that he had an aggressive bladder cancer. Mr Snary attended several hospital consultations to discuss possible cancer treatments. Due to his complicated medical history, specialists were concerned about the possible effects of being under anaesthetic and his ability to cope with major surgery.

16. On 31 August 2020, Mr Snary had a heart attack. On 10 September, the hospital consultant cardiologist considered whether he was suitable for a coronary artery bypass graft operation. However, due to his poor mobility and other physical conditions, it was felt that he would not survive the procedure.

17. On 1 October, Mr Snary told healthcare staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

18. On 5 October, Mr Snary collapsed in his cell. He told healthcare staff that he was short of breath and had vomited. Healthcare staff arranged for his transfer to Dorset County Hospital. Hospital staff told prison healthcare staff that Mr Snary was in the High Dependency Unit and that they had stabilised his condition. However, they said that there was a high possibility he would have another heart attack.

19. On 7 October 2020, it was confirmed that Mr Snary had died in hospital.

Post-mortem report

20. The Coroner gave Mr Snary's cause of death as a recent myocardial infarction (heart attack) caused by ischaemic heart disease. He also had hypertension (high blood pressure) which did not cause but contributed to his death.

Lisa Burrell
Assistant Ombudsman **March 2021**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141