Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Vernon, a prisoner at HMP Dovegate, on 19 February 2021

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 | 020 7633 4100
F | 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*

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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 Peter Vernon, who was 73 years old, died in hospital from prostate cancer on 19 February 2021, while a prisoner at HMP Dovegate. We offer our condolences to Mr Vernon's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Vernon received at Dovegate was of a good standard and equivalent to that which he could have expected to receive in the community.

5. However, we are concerned that during a hospital stay in November 2020, Mr Vernon remained double cuffed for 13 days, until hospital staff complained that they could not care for him properly. (Double cuffing is when the prisoner's hands are handcuffed in front of him, and one wrist is attached to a prison officer by an additional set of handcuffs.) Not only was the level of restraints disproportionate given Mr Vernon's age and state of health, but it impacted on the care he received in hospital and resulted in multiple skin wounds on various parts of his body. This was unacceptable.

Recommendations

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
    - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Director should share this report with the manager who authorised the use of double cuffs and discuss the Ombudsman's findings with her.
- The Executive Director of Custodial Contracts should write personally to the Ombudsman explaining what he is doing to ensure that effective action is taken on the inappropriate use of restraints at HMP Dovegate.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Vernon’s clinical care at HMP Dovegate.

7. The PPO investigator has investigated the non-clinical issues in Mr Vernon’s care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. She interviewed three members of staff which, due to coronavirus restrictions, took place by telephone.

8. One of our family liaison officers wrote to Mr Vernon’s next of kin, his daughter, to explain the investigation. She did not respond.

9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP Dovegate

10. Mr Vernon was the ninth prisoner to die at Dovegate since February 2019. Of the previous deaths, five were from natural causes, two were self-inflicted and one was drug related.

11. We have not previously made recommendations to Dovegate about the inappropriate use of restraints on prisoners being taken to hospital. However, we note that in two previous investigations, Dovegate was unable to provide the PPO with escort risk assessments and bedwatch logs which meant that the PPO investigator could not establish the level of restraints used.

Key Events

12. In December 2005, Mr Peter Vernon was sentenced to life in prison for murder. In August 2008, he was moved to HMP Dovegate.

13. Mr Vernon had several long-term health issues including diabetes and hypertension (high blood pressure) and had previously had a stroke. In 2018, he was diagnosed with prostate cancer, which was managed with hormone treatment.

14. In January 2020, Mr Vernon was moved to the inpatient resettlement unit at Dovegate because of his complex health needs.

15. On 1 November, Mr Vernon was sent to hospital because he had blood in his faeces. Mr Vernon was escorted by two officers and was restrained using the double cuffing method. (Double cuffing is when the prisoner’s hands are handcuffed in front of him, and one wrist is attached to a prison officer by an additional set of handcuffs.) While in hospital he was diagnosed with stage three acute kidney infection, a gastric bleed (bleeding that occurs within your digestive tract) and cellulitis of his left leg. On 15 November, he returned to prison where a full health and social care package was increased to four times daily.

16. On 17 November, a nurse saw Mr Vernon and noted that he had pressure ulcers and deep tissue injuries, which had been acquired while in hospital. Mr Vernon had eight wounds in total.

17. Over the next few months, Mr Vernon’s health deteriorated, and he was admitted to hospital on several occasions. On 12 January 2021, he tested positive for COVID-19. He was sent to hospital where he was treated until 28 January, when he was discharged and sent back to prison.

18. On 31 January, a nurse saw Mr Vernon. She took his clinical observations and noted that he had a National Early Warning Score (NEWS) of five. (NEWS is a tool used to assess clinical deterioration in adult patients - a score of five indicates medium clinical risk that requires an urgent response.) Healthcare staff called an ambulance and Mr Vernon was taken to hospital where he was later admitted. His prognosis was poor so advanced end of life care planning was agreed.

19. Hospital staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Vernon, who agreed that if he stopped breathing, he did not want to be resuscitated. On 10 February, Mr Vernon was discharged from hospital and sent back to prison.

20. On 17 February, a nurse saw Mr Vernon. She took his clinical observations and noted that he had a NEWS score of seven (high clinical risk). Healthcare staff called an ambulance and Mr Vernon was taken back to hospital, where he was again admitted.

21. The hospital consultant made the decision to withdraw treatment and put Mr Vernon on an end-of-life pathway. Mr Vernon died on 19 February.

22. The post-mortem report concluded that Mr Vernon died of sepsis caused by pulmonary embolism, which had been caused by cancer of the prostate. Diabetes was listed as a contributory factor.

Non-Clinical Findings

Security risk assessments and the use of restraints

23. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

24. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

25. When Mr Vernon was taken to hospital on 1 November 2020, he was restrained using double cuffs. The medical information section of the risk assessment noted that Mr Vernon could not move unaided and used a Zimmer frame. We consider that the authorising manager failed to take account of this information when she decided that Mr Vernon should be restrained with double cuffs. When she was asked at interview why she made this decision, she said that the National Security Framework says that category B prisoners should be double cuffed. She added that healthcare staff had indicated on the risk assessment that there was no medical reason why Mr Vernon could not be double cuffed and therefore, as he was a category B prisoner, she authorised double cuffs.

26. We are very concerned that this decision appears to have been based solely on Mr Vernon's security category. There appears to have been no consideration of Mr Vernon's risk of escape which, given his poor mobility and state of health, would have been very low. We consider that the use of double cuffs was disproportionate to the risk Mr Vernon posed.

27. On 13 November, hospital staff complained to prison staff that they were unable to provide proper care to Mr Vernon because of the restraints. Mr Vernon had developed pressure sores on his back because he had not been turned frequently enough and was starting to develop sores on his wrists. The same day a prison manager reviewed the risk assessment and downgraded Mr Vernon's restraint level to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to a prison officer's wrist). We note that on the risk assessment, the prison manager described Mr Vernon as very frail and said that Mr Vernon's age and medical condition suggested that he was unable to escape.

28. On 15 November, when Mr Vernon returned to Dovegate, prison healthcare staff found that he had multiple injuries to his skin, including pressure sores and deep tissue injuries.

29. We are extremely concerned that Mr Vernon remained double cuffed for 13 days while he was in hospital. Not only was this undignified but it caused Mr Vernon unnecessary suffering. We are appalled that no one reviewed the level of restraints being used on Mr Vernon until hospital staff complained that they could not treat him properly with the restraints in place.

30. We recommend:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

The Director should share this report with the manager who authorised the use of double cuffs and discuss the Ombudsman's findings with her.

The Executive Director of Custodial Contracts should write personally to the Ombudsman explaining what he is doing to ensure that effective action is taken on the inappropriate use of restraints at HMP Dovegate.

Louise Richards **October 2021**
Assistant Ombudsman

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