Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vernon Saunders a prisoner at HMP Dartmoor on 16 August 2017

A report by the Prisons and Probation Ombudsman

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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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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.

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

Mr Vernon Saunders died in hospital on 16 August 2017 of septicaemia and bronchopneumonia while a prisoner at HMP Dartmoor. He was 82 years old. I offer my condolences to Mr Saunders' family and friends.

When Mr Saunders became unwell on 10 August 2017 his condition was not properly monitored. Healthcare staff did not take his clinical observations or use a clinical assessment tool to establish the seriousness of his condition until 13 August, by which time he needed immediate medical attention and was taken to hospital. Poor record keeping also contributed to the lack of proper monitoring.

Overall the clinical care Mr Saunders received was not equivalent to that which 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

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Summary

Events

1. Mr Vernon Saunders was serving a 10-year sentence for sexual offences and arrived at HMP Dartmoor in August 2012. He had a history of poor health which included ischaemic heart disease, high blood pressure, rheumatoid arthritis and anaemia.

2. On 10 August 2017, Mr Saunders became unwell. A nurse examined him and noted he had swollen legs and was very frail. The same day, a prison GP diagnosed mild dehydration.

3. On 11 August, a nurse and the healthcare manager saw Mr Saunders and advised him to drink fluids. On 12 August, a nurse saw Mr Saunders who was unable to take his prescribed medication. She administered his medication and encouraged him to drink fluids.

4. On 13 August, a nurse saw Mr Saunders and noted that his blood pressure, pulse rate and oxygen saturation level were low. The nurse called an out of hours GP who, after examining Mr Saunders, called an emergency ambulance.

5. Hospital doctors treated Mr Saunders with intravenous antibiotics. Mr Saunders continued to deteriorate and died in hospital at 10.30pm on 16 August. Hospital doctors recorded that he died from septicaemia and bronchopneumonia, with ischaemic heart disease a contributory factor.

Findings

6. None of the nurses who saw Mr Saunders on 10, 11 and 12 August, took his clinical observations and a clinical assessment tool was not used until 13 August. As a result, there was a delay in assessing the seriousness of his condition and whether it was deteriorating.

7. The clinical reviewer considered that poor record keeping by healthcare staff contributed to the lack of effective monitoring. The doctor who examined Mr Saunders on 10 August did not make a proper record and did not set out a clear plan on how Mr Saunders should be monitored going forward.

8. We agree with the clinical reviewer that Mr Saunders' clinical care was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that healthcare staff use a structured assessment tool, such as NEWS, to help assess and monitor acute illness and that they respond appropriately to any deterioration in the patient's condition.

- The Head of Healthcare should ensure that healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council. An audit of record keeping should be undertaken to check compliance with professional standards and the outcomes acted upon.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded

10. The investigator obtained copies of relevant extracts from Mr Saunders' prison and medical records.

11. The investigator interviewed one member of staff on 20 December 2017.

12. NHS England commissioned a clinical reviewer to review Mr Saunders' clinical care at the prison. The clinical reviewer conducted a joint interview with the investigator.

13. We informed HM Coroner for Torbay and South West Devon of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Saunders' son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Saunders' son did not respond to our letter.

15. Our investigation was suspended between 27 November 2017 and 29 May 2018 while we awaited the final clinical review report. The completion of this report was delayed as a result.

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

Background Information

HMP Dartmoor

17. HMP Dartmoor holds up to 640 adult male prisoners. It has six residential wings known as ‘tors’. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership Trust. Healthcare staff are on duty between 7.45am and 6.30pm on weekdays and between 8am and 5.30pm at weekends

HM Inspectorate of Prisons

18. The last inspection at HMP Dartmoor was in August 2017. Inspectors reported that while the availability of primary care assessment was reasonable, it had been affected by staff shortages. It noted that nurses’ clinics were often interrupted or cancelled with nurses having to cover alternative tasks.

19. Inspectors also noted that the standard of monitoring of some patients with long term conditions had deteriorated in comparison to their previous inspection and found cases in which diagnostic tests had not been ordered. However, as in their previous inspection, they noted there was particularly good support for older prisoners and those with disabilities.

Independent Monitoring Board

20. 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 30 September 2017, the IMB reported that staff shortages in healthcare were an issue. There had been periods when, if managers had not intervened by taking clinics, there would not have been enough nursing staff to run a safe shift.

21. As in previous reports, the Board reported that the increasing number of elderly prisoners with complex health problems caused difficulties for healthcare and for the prison.

Previous deaths at HMP Dartmoor

22. Mr Saunders was the sixth prisoner to die since August 2015 while a prisoner at Dartmoor and the fourth prisoner to die from natural causes. In addition, one was murdered and one took his own life. There have been two deaths from natural causes since. There were no similarities between Mr Saunders’ death and previous deaths at Dartmoor.

Key Events

23. On 3 August 2012, Mr Vernon Saunders was sentenced to 10 years in prison for sexual offences and sent to HMP Gloucester. On 11 August 2012, he was sent to HMP Bristol and then to HMP Dartmoor on 22 August 2012.

24. At an initial health screen at Dartmoor, a nurse noted that Mr Saunders had a history of ischaemic heart disease, high blood pressure and swollen ankles. She noted that Mr Saunders had regular hospital appointments to monitor his rheumatoid arthritis. A prison GP prescribed medication for heart failure, high blood pressure and to lower cholesterol, which Mr Saunders kept in his possession.

25. On 18 September 2012, a prison GP arranged a full set of blood tests and the results showed Mr Saunders was anaemic. She noted that the likely cause was Mr Saunders' prescribed medication. Healthcare staff monitored Mr Saunders' anaemia while he was at Dartmoor and in October 2014, a prison GP diagnosed iron deficiency anaemia. In April 2016, a prison GP diagnosed anaemia due to chronic illness.

26. In January and July 2014, Mr Saunders was admitted to hospital with chest pain. Hospital doctors diagnosed intermittent atrial fibrillation (an irregular and often abnormally fast heart rate) and narrowing of the coronary arteries. Healthcare staff continued to monitor Mr Saunders and GPs reviewed his prescribed medication.

27. On 16 September 2015, Mr Saunders was taken to hospital with chest pain. Hospital doctors diagnosed atrial fibrillation and right ventricle failure and increased Mr Saunders' prescribed heart disease medication.

28. Throughout 2016, prison GPs reviewed Mr Saunders regularly and monitored his cholesterol levels. In May 2016, his cholesterol level was recorded as satisfactory and blood and liver function tests were normal.

29. On 28 April 2017, Mr Saunders saw a hospital rheumatologist who said Mr Saunders' rheumatoid disease was in remission. The rheumatologist wrote to a prison GP the same day and said he had stopped Mr Saunders' medication for rheumatoid arthritis.

30. On 7 June, a prison GP examined Mr Saunders who complained of swelling in both legs. Mr Saunders' blood pressure was normal (122/77mmhg) and his oxygen saturation level was 96% (normal). A prison GP diagnosed heart failure and prescribed medication to reduce Mr Saunders' fluid in his legs.

31. On 10 August, a nurse saw Mr Saunders in his cell. Mr Saunders said he felt unwell and she noted that Mr Saunders appeared very frail and his legs were swollen.

32. Later that day, a prison GP assessed Mr Saunders and noted that he was immobile. Mr Saunders' tongue appeared dry and Mr Saunders said he had not eaten or had much to drink that day. A prison GP recorded Mr Saunders' blood pressure as normal (108/74mmhg) and his oxygen saturation level as 97%

(normal). The GP noted that Mr Saunders was mildly dehydrated and he recommended a move to F wing where Mr Saunders could be better supported. Mr Saunders moved to F wing the same day and was allocated a prison carer to support him.

33. On 11 August, a nurse and the healthcare manager saw Mr Saunders in his cell. The nurse noted that Mr Saunders appeared dishevelled and was eating his tea slowly. Mr Saunders' drinking cups were full and he advised him to drink fluids.

34. On 12 August, a nurse saw Mr Saunders in his cell and noted that he was unable to take his prescribed medication. She gave Mr Saunders his medication and encouraged him to drink fluids.

Events of 13 August

35. At 8.30am on 13 August, a nurse went to Mr Saunders' cell. She noted that Mr Saunders had not taken any fluids overnight and appeared groggy. She gave Mr Saunders fluids.

36. At 10.59am, the nurse returned to Mr Saunders' cell. She recorded his blood pressure as low (100/45) his pulse rate as low (45bpm) and his oxygen saturation level as 90% (low). She noted that Mr Saunders' National Early Warning Score (NEWS) was 7. (NEWS is a clinical assessment tool used to support decisions around a patient's clinical condition. A score is allocated to physiological measurements, an increasing score indicates a clinical deterioration, a score of 7 is high, the emergency response threshold, and indicates that a patient requires continuous monitoring.) She called an out of hours GP to assess Mr Saunders because prison GPs were not on duty as it was Sunday.

37. At 2.38pm. an out of hours GP examined Mr Saunders and recorded that his temperature was low and unreadable. Mr Saunders' oxygen saturation level was 85% (low). He arranged for an emergency ambulance to take him to hospital. Two prison officers accompanied Mr Saunders and did not use restraints.

38. Hospital doctors treated Mr Saunders with intravenous antibiotics and fluids. Mr Saunders continued to deteriorate and he died at 10.30pm on 16 August. Hospital doctors recorded that Mr Saunders died from septicaemia and bronchopneumonia, with ischaemic heart disease a contributory factor.

Contact with Mr Saunders' family

39. A member of the prison chaplaincy acted as the prison's family liaison officer (FLO). On 13 August, the FLO contacted Mr Saunders' son, his nominated next of kin, and told him Mr Saunders was in hospital. Mr Saunders' son asked to be informed of Mr Saunders' death by telephone.

40. At 11.25pm on 16 August, the FLO telephoned Mr Saunders' son and informed him of Mr Saunders' death. The FLO remained in contact with Mr Saunders' son until Mr Saunders' funeral on 14 September. The prison arranged and contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

41. After Mr Saunders' death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

42. 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 Mr Saunders' death.

Post-mortem report

43. The Coroner accepted the cause of death provided by the hospital doctors and no post-mortem was carried out.

Findings

Clinical care

44. None of the nurses who saw Mr Saunders on 10, 11 and 12 August, took his clinical observations or used the NEWS assessment tool to monitor his condition. The clinical reviewer commented that the use of a structured tool such as the NEWS system, based on six routine clinical observations, would have helped determine the severity of Mr Saunders' condition and given a clear set of observations for further monitoring.

45. On 13 August, a nurse recorded Mr Saunders' NEWS score as 7 and made a referral to the out of hours GP. The clinical reviewer considered that Mr Saunders' NEWS score indicated that he required an immediate medical assessment and that calling an emergency ambulance would have been a better option than calling for an out of hours GP, for which response times are slower. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff use a structured assessment tool, such as NEWS, to help assess and monitor acute illness and that they respond appropriately to any deterioration in the patient's condition.

Record keeping

46. The clinical reviewer considered that the standard of record keeping by healthcare staff towards the end of Mr Saunders' life was poor. A prison GP told the investigator and clinical reviewer at interview that he fully examined Mr Saunders on 10 August but time pressure prevented him from properly recording the results in Mr Saunders' medical record.

47. The prison GP said he did not consider that Mr Saunders was critically ill and he recommended hospital admission if his condition deteriorated. However, he did not record this in Mr Saunders' medical record or specify how nurses should monitor Mr Saunders to assess if his condition deteriorated.

48. Nurses who saw Mr Saunders on 10,11 and 12 August noted general observations about his appearance but did not record his basic clinical observations. The Code for Nurses and Midwives recommends that nurses should "identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need". The clinical reviewer considered that the care provided to Mr Saunders did not meet this standard.

49. The clinical reviewer concluded that Mr. Saunders required urgent medical assessment on 13 August, but it was impossible to be sure how his illness had progressed from 10 August due to the poor standard of record keeping. We agree with the clinical reviewer that Mr Saunders' clinical care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council. An audit of record keeping should be undertaken to check compliance with professional standards and the outcomes acted upon.

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