Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Saunders, a prisoner at HMP Pentonville, on 13 April 2021

A report by the Prisons and Probation Ombudsman

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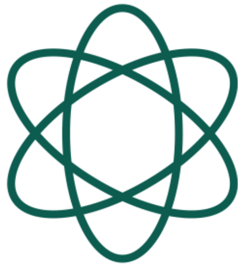
Our vision

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 Roger Saunders died of bronchopneumonia (inflammation of the lungs caused by an infection) on 13 April 2021 while a prisoner at HMP Pentonville. He also had chronic obstructive pulmonary disease (COPD, a lung disease) and was immobile. These factors contributed to but did not cause his death. He was 76 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Saunders received at Pentonville was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

Mr Saunders was bedbound, frail and underweight when he went to Pentonville. We are concerned that he was never weighed in prison because there were no suitable scales. While we are also concerned that Mr Saunders received inadequate social care, we note that a new social care contract with the healthcare service provider has been put in place since his death. The clinical reviewer is satisfied that improvements have been made since then.

When Mr Saunders felt unwell on 9 April, healthcare staff failed to take his observations which could have led to an earlier admission to hospital.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2022**

Contents

Summary 1

The Investigation Process...3

Background Information..4

Key Events..5

Findings 8

Summary

Events

1. On 28 November 2017, Mr Roger Saunders was sentenced to eight years in prison for sex offences and was sent to HMP Pentonville.

2. Mr Saunders had long-term health conditions, he was underweight and had been housebound from 2012 and bedbound from 2015. He had social care in place from 29 November 2017.

3. At his second health screen, a nurse manager noted that Mr Saunders weighed 52 kilograms, although she did not weigh him. On 1 December, a prison GP reviewed Mr Saunders and noted that he was cachexic (wasting away). On 4 December, an occupational therapist assessed Mr Saunders and found that he was emaciated, his muscles had wasted away, and he weighed about five stones (32 kilograms).

4. On 19 October 2018, a prison GP noted that although he had no means to weigh Mr Saunders, he appeared to have lost weight.

5. On 5 August 2019, a prison GP noted that they were unable to determine Mr Saunders' weight loss because they still did not have suitable scales to weigh him. He planned to get a set of sitting scales.

6. On 9 April 2021, a prison GP saw Mr Saunders because he had a sore throat, a cough and was producing green phlegm. He did not have a fever, but his tonsils were inflamed with pus. The prison GP gave him a throat spray (for pain relief and inflammation) and an antibiotic and planned to send him to hospital the following morning if he had not passed urine. The prison GP asked a nurse to take his blood oxygen saturation level, but the nurse was unable to get a reading. Healthcare staff did not take his observations.

7. On 11 April, when two healthcare assistants saw Mr Saunders for his personal care, they found him covered in faeces. A nurse found that his breathing became shallow, he was disorientated and did not respond to her verbal commands. The nurse was unable to record Mr Saunders' blood oxygen saturation level and found that his pulse was very weak. An officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing and triggers the control room to call an ambulance immediately). A nurse gave him oxygen. Paramedics arrived soon afterwards and took him to hospital by ambulance.

8. On 13 April, Mr Saunders died in hospital. A post-mortem examination established that Mr Saunders died of bronchopneumonia. He also had COPD and immobility which contributed to but did not cause his death.

Findings

Clinical care

9. The clinical reviewer found that the clinical care that Mr Saunders received at Pentonville was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

10. On 9 April 2021, when a prison GP saw Mr Saunders for a sore throat and a productive cough, he did not take his physical observations. The clinical reviewer said that if observations had been taken, this may have led to an earlier admission to hospital.

Social care

11. The clinical reviewer found that the social care that Mr Saunders received at Pentonville was not equivalent to that which he could have expected to receive in the community. Mr Saunders' social care was inconsistent as carers were not always available at the prison. On 1 April 2021, Practice Plus Group, the healthcare provider at Pentonville, took over the social care contract and the clinical reviewer is satisfied that improvements have been made to the service since then.

Weight management

12. Mr Saunders was underweight but he was never weighed at Pentonville because suitable scales were never available. Healthcare staff never accurately recorded Mr Saunders' weight in his medical records or considered other means of assessing his weight and they relied inaccurately on previously recorded weights from his medical records.

Recommendations

- The Head of Healthcare should ensure that when assessing a prisoner with an apparently minor illness, healthcare staff take a set of physiological observations to understand the severity of the illness.
- The Head of Healthcare should ensure that when a prisoner is unable to be weighed using standard or seated scales, an alternative method of weighing should be used.
- The Head of Healthcare should ensure that entries in a prisoner's medical records accurately show his weight at that time and are not based on previous entries.

The Investigation Process

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

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

15. The investigator interviewed a member of staff by telephone on 2 September.

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

17. We informed HM Coroner for Inner North London of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

18. The Ombudsman's family liaison officer wrote to Mr Saunders' cousin to explain our investigation. He had no specific questions.

19. We shared the initial report with the Prison Service. There were no factual inaccuracies, and their action plan has been appended to this report.

20. We shared the initial report with Mr Saunders' cousin. He did not respond.

Background Information

HMP Pentonville

21. HMP Pentonville is a local prison in London that holds around 900 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group, formerly known as Care UK, in partnership with Barnet, Enfield and Haringey Mental Health Trust, provides healthcare services at the prison.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Pentonville was in April 2019. Inspectors found that the response to recommendations made by the Prisons and Probation Ombudsman following deaths in custody was inadequate. Living conditions for many prisoners were poor, with nearly a third locked in their cells during the working day.

23. Due to their concerns about the prison, inspectors returned to Pentonville in February 2020 to conduct an independent review of progress. They reported that the prison had made good progress in just one out of fifteen of HMIP's recommendations. Inspectors noted that this was highly concerning and the worst progress they had seen in any progress review. They wrote to the Secretary of State to express their concerns.

24. In November 2020, inspectors carried out a short scrutiny visit and found that there had been some progress. They found that prison managers continued to focus on the key priorities set at the last inspection while managing the additional problems created by COVID-19. However, inspectors found that the prison remained overcrowded, understaffed and social distancing was all but impossible in some areas. Healthcare was reasonable but demand was high and healthcare provision was stretched.

Independent Monitoring Board

25. 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 2021, the IMB reported that due to COVID-19, prisoners were confined to their cells for up to 23 hours a day and that in-cell telephones were a lifeline for prisoners to keep in touch with families and for the most anxious to call the Samaritans. The IMB reported that prison management and healthcare had saved many lives by coordinating a stringent isolation and testing regime.

Previous deaths at HMP Pentonville

26. There were three deaths from natural causes at HMP Pentonville in the two years before Mr Saunders' death, including two from COVID-19, six self-inflicted deaths and a drug-related death. There has been one self-inflicted death at Pentonville since Mr Saunders' death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

27. On 28 November 2017, Mr Roger Saunders was sentenced to eight years in prison for sex offences and was sent to HMP Pentonville.

28. Mr Saunders had asthma, depression, glaucoma and arthritis. He was underweight and had been housebound since 2012 and bedbound from 2015.

29. At his initial health screen, a nurse noted that Mr Saunders was very frail but conscious and alert. A prison GP locum noted that he was frail and unable to straighten his legs. The GP planned for Mr Saunders to live on a standard wing in a cell adapted for a prisoner with physical disabilities, to have support from a carer and a weekly nurse review.

30. On 29 November, an equalities officer saw Mr Saunders and sent a social care referral to the local authority. The officer said that Mr Saunders was very small, skinny and frail and that he was very difficult with prison and healthcare staff. He said that they had prepared for Mr Saunders' arrival, and he received social care from that day onwards.

31. At his second health screen, a nurse manager saw Mr Saunders, who told her that he ate his meals lying on his side in bed. She noted that Mr Saunders weighed 52 kilograms and was underweight, but she did not weigh him.

32. On 1 December, a prison GP reviewed Mr Saunders and noted that he was cachexic. Mr Saunders refused to have nutritional supplements.

33. On 4 December, an occupational therapist, employed by Islington Council, assessed Mr Saunders and found that he was emaciated, had obvious muscle wastage and weighed about five stones (32 kilograms). She recommended that Mr Saunders should have an air mattress because he was at high risk of pressure sores but he said that he did not want one. Mr Saunders agreed to have a foam mattress instead.

34. On 7 December, Mr Saunders received a new profiling bed, an adjustable bed table, a free-standing commode and sliding board. The next day, the occupational therapist went back to see him with the new equipment in place. He declined to see a physiotherapist.

35. On 13 March 2018, Mr Saunders was moved to the inpatient unit because a prison GP was concerned that he was not receiving adequate social care. The GP was also concerned that he was living on a main wing in an open cell which was easily accessible by other prisoners. Healthcare staff planned to take his observations daily, monitor his oral intake, take routine blood tests and assess his pressure sores.

36. On 15 March, a prison GP found that Mr Saunders had a vitamin D deficiency and prescribed him cholecalciferol.

37. On 4 April, Mr Saunders was moved to a cell adapted for a prisoner with physical disabilities on F wing. On 16 May, social care staff from Islington local authority

assessed that Mr Saunders needed help with personal care and hygiene, setting up his meals and support with cleaning his cell.

38. On 17 July, at a multidisciplinary team meeting, a prison GP noted that Mr Saunders was losing weight, but they did not have a hoist to weigh him.

39. On 19 October, a prison GP noted that Mr Saunders appeared to have lost weight, but he had no means to weigh him. Mr Saunders was eating breakfast, two baguettes each day and biscuits from the canteen. He declined to see a dietician or to take nutritional supplements.

40. On 8 January 2019, a prison GP noted that Mr Saunders had lost more weight and was more emaciated. He again declined to see a dietician or to take nutritional supplements.

41. On 5 August, at a multidisciplinary team meeting, a prison GP noted that they were unable to determine Mr Saunders' weight loss because they still did not have suitable scales to weigh him. They planned to get a set of sitting scales and refer him to a dietician. On 27 April 2020, at a multidisciplinary team meeting, a prison GP noted that Mr Saunders should be weighed when the scales became available.

42. On 14 January 2021, a prison GP planned with the social service team for Mr Saunders' discharge from prison. He asked for the weighing chair to be taken from the inpatient unit to F wing, but he was told that the scales were out of order. Suitable weighing scales were never available for use.

43. On 1 April, a prison GP prescribed Mr Saunders a nutritional supplement.

44. On 9 April, a prison GP saw Mr Saunders because he had a sore throat, a cough and was producing green phlegm. Mr Saunders did not have a fever, but his tonsils were inflamed with pus. The GP prescribed a throat spray and an antibiotic and planned to send him to hospital the following morning if he had not passed urine. He asked a nurse to take his blood oxygen saturation level, but the nurse was unable to get a reading. Healthcare staff did not take his observations.

45. The following day, Mr Saunders passed urine and drank some fluids, but ate little. Healthcare staff did not take his observations.

46. On 11 April, two Healthcare Assistants (HCA) went to help Mr Saunders with his personal care. They found him covered from head to toe in faeces. They gave him a bed bath and dressed him. One noted that Mr Saunders was chesty and could not speak coherently. A nurse gave him his medication and noticed that his breathing had become shallow, he was disorientated and did not respond to her verbal commands. The nurse was unable to record Mr Saunders' blood oxygen saturation level and found that his pulse was very weak. At 10.12am, an officer radioed a medical emergency code blue. The nurse gave him oxygen. At 10.20am, ambulance paramedics were at his side and at 10.59am, transferred him to hospital, unrestrained, where he died on 13 April.

Contact with Mr Saunders' family

47. On 13 April 2021, the prison appointed a family liaison officer (FLO). The FLO telephoned Mr Saunders' cousin to tell him that Mr Saunders was in hospital, that his health had deteriorated and that he could visit him in hospital. Mr Saunders' cousin arrived at the hospital shortly after he died.

48. After Mr Saunders died, the FLO telephoned his cousin and offered his condolences. Mr Saunders' funeral took place on 25 May, and the prison contributed to its cost in line with national instructions.

Support for prisoners and staff

49. After Mr Saunders' death, a prison manager debriefed the staff who were on duty at the hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Saunders' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Saunders' death.

Post-mortem report

51. A post-mortem examination established that Mr Saunders died from bronchopneumonia. He also had COPD and was immobile. These factors contributed to but did not cause his death.

Findings

Clinical care

52. The clinical reviewer found that the clinical care that Mr Saunders received at Pentonville was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

53. On 9 April 2021, when a prison GP saw Mr Saunders for a sore throat and a productive cough, his physical observations were not taken. The clinical reviewer said that if observations had been taken, this may have led to an earlier admission to hospital. However, the clinical reviewer said that given his age, frailty, and underlying lung disease, it is unlikely to have prevented his death. We make the following recommendation:

    The Head of Healthcare should ensure that when assessing a prisoner with an apparently minor illness, healthcare staff take a set of physiological observations to understand the severity of the illness.

Social care

54. The clinical reviewer found that the social care that Mr Saunders received at Pentonville was not equivalent to that which he could have expected to receive in the community. The clinical reviewer said that when Mr Saunders went to Pentonville, he was elderly, frail, and bedbound and had care visits three times a day. Initially, care at the prison was poor and, on many days, he had no care at all.

55. The equalities officer said that when Mr Saunders arrived at Pentonville, prison staff were responsible for arranging social care. He said that the contract for social care was with Islington local authority who sub-contracted the care to a company called CRG. He said that CRG supplied a carer who remained in the prison seven days a week from 8.00am to 8.00pm. He disagreed with the clinical reviewer's findings and noted that there was a carer in the prison for much of the time seven days a week but agreed that there were some shortcomings with the service.

56. The equalities officer said that Mr Saunders was also supported by a prisoner care support buddy who was responsible for cleaning his cell and collecting his meals.

57. The equalities officer said that on 1 April 2021, the healthcare provider at the prison took over responsibility for providing social care. He said that Practice Plus Group now provide an occupational therapist, three healthcare assistants and an administrator to provide social care. He said that the new system was much improved because healthcare professionals were responsible for the social care of prisoners.

58. The Head of Healthcare said that since they had taken over the responsibility for social care, all prisoners who need social care have a full assessment and a care plan which is regularly updated. He said that daily entries are made in medical records, explaining the care that is being delivered.

59. We accept that when Mr Saunders first arrived at Pentonville, there were shortcomings with his social care. However, since 1 April 2021, healthcare staff have taken over the contract to provide social care for prisoners and a new system is in place. We therefore make no recommendation.

Weight management

60. When Mr Saunders went to Pentonville, he was underweight. However, he was not weighed in prison. Despite many entries in Mr Saunders' medical records to state that a set of suitable scales were to be made available, they were never provided. The clinical reviewer said that entries about Mr Saunders' weight were taken from previous entries in his medical records.

61. The clinical reviewer found that Mr Saunders was underweight when he went to Pentonville and that his initial weight recorded in the medical records did not match community findings and appears to have been taken from much earlier medical records. She found that Mr Saunders was not weighed at Pentonville and there was no evidence that healthcare staff used any other means of assessing his nutritional status. We make the following recommendations:

The Head of Healthcare should ensure that when a prisoner is unable to be weighed using standard or seated scales, an alternative method of weighing should be used.

The Head of Healthcare should ensure that entries in a prisoner's medical records accurately show his weight at that time and are not based on previous entries.

62. Mr Saunders frequently refused personal care, food, medication, recording of his observations and was abusive to staff and carers. Healthcare staff found that he had the mental capacity to decide to refuse dietary advice and supplements.

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