

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Snashfold, a prisoner at HMP The Verne, on 4 November 2021

A report by the Prisons and Probation Ombudsman



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 Gordon Snashfold died in hospital on 4 November 2021 of lung cancer while a prisoner at HMP The Verne. Mr Snashfold was 75 years old. I offer my condolences to Mr Snashfold's family and friends.
4. The clinical reviewer concluded that healthcare staff failed to refer Mr Snashfold for an urgent (two week wait) appointment when he presented with symptoms of suspected cancer. The clinical reviewer also identified missed opportunities to escalate Mr Snashfold's care when his NEWS2 score was three (NEWS2 is a tool to detect acute illness and deterioration, a score of three indicates that an urgent review by a nurse is needed). She also concluded that staff should have started end of life care discussions with Mr Snashfold. She made nine recommendations, three of which are listed below. The other recommendations were not directly related to Mr Snashfold's death, but the Head of Healthcare will need to address them.
5. We are concerned that prison staff did not radio a code blue (an emergency code which indicates a prisoner is not breathing or is having difficulty breathing) when Mr Snashfold was found struggling to breathe on 28 September 2021. This is contrary to Prison Service Instructions. We are concerned to be raising this issue in this investigation for the third time in the last two years.

Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of how to identify and refer into suspected cancer pathways, in accordance with NICE guidelines.
- The Head of Healthcare should ensure that staff are aware of, and follow, the recommended clinical escalation procedures when using the National Early Warning Score (NEWS) assessment tool.
- The NHSE Commissioner for the South (South West) region should write to the Ombudsman setting out what she is doing to satisfy herself that healthcare staff at The Verne are consistent in understanding and following National Guidelines when using the NEWS assessment tool.
- The Head of Healthcare should ensure that end of life discussions are considered at an early stage for ageing patients with complex and long-term health problems, to include palliative care and any advanced decisions they wish to make.

- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code to alert control room staff to call an ambulance automatically.
- The Prison Group Director for Avon and South Dorset prisons should write to the Ombudsman setting out what he is doing to satisfy himself that responses to medical emergencies are being conducted at The Verne in line with national guidance.

The Investigation Process

6. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Snashfold's clinical care at The Verne.
7. The PPO investigator has investigated non-clinical issues, including Mr Snashfold's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The investigator interviewed two prisoners on 19 January 2022 and two members of staff on 3 March 2022, by telephone. She also met the Head of Healthcare with the clinical reviewer on 28 January 2022.
9. The PPO family liaison officer wrote to Mr Snashfold's next of kin, his daughter, to explain the investigation. She did not have any specific questions for us to consider.
10. Mr Snashfold's family received a copy of the draft report. They did not make any comments.
11. 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

12. There were nine deaths from natural causes in the two years before Mr Snashfold's death, five of these were related to COVID-19. There have been two further deaths due to natural causes since that of Mr Snashfold.
13. Two previous investigations have made recommendations in relation to NEWS2 scores. In January and November 2021, the Head of Healthcare accepted these recommendations, and it is a concern that this has not yet been successfully addressed.
14. In January and November 2021, the Governor and Head of Healthcare accepted our recommendations to ensure that all staff were aware of their responsibilities during medical emergencies. It is also concerning that this remains an issue.

Key Events

15. On 18 December 2014, Mr Snashfold was sentenced to 21 years imprisonment. He was sent to HMP Whatton and was transferred to HMP The Verne on 28 June 2019.
16. On reception into custody, Mr Snashfold had a complex medical history, including cancer of the bladder, high blood pressure, Chronic Obstructive Pulmonary Disease (COPD - a progressive lung disease causing breathing difficulties), chronic kidney disease, high cholesterol and clinical obesity.
17. On 20 August 2021, a nurse saw Mr Snashfold, as he had chest pains and a cough. He was appropriately given a COVID-19 PCR test and advised to immediately self-isolate in the care and supervision unit (CSU). The Head of Healthcare said that most wings at The Verne have shared facilities and the CSU is the only safe environment available for self-isolation. Mr Snashfold was seen daily by healthcare staff and had access to his usual regime while he was in the CSU.
18. On 26 August, Mr Snashfold asked to see healthcare staff as his chest pains were keeping him awake at night. A nurse assessed Mr Snashfold and gave him an appointment to see an Advanced Nurse Practitioner (ANP) on 8 September. This appointment was cancelled as the ANP was unavailable for the appointment.
19. Mr Snashfold's original PCR test got lost in the post. A further PCR test was done on 23 August. On 27 August, Mr Snashfold returned to the general wing, presumably due to a negative PCR test, although this result was not entered on his medical record.
20. A prison GP assessed Mr Snashfold on 10 September as he had reported coughing up blood. She prescribed Mr Snashfold antibiotics and made a routine referral for a chest x-ray. Mr Snashfold was not referred for a two week wait appointment in line with NICE guidelines.
21. On 16 September, an ANP assessed Mr Snashfold, as he had been short of breath. Mr Snashfold was offered an inhaler and a space chamber (designed to deliver more inhaled medication to the lungs) and he was given advice on how to manage his shortness of breath. The ANP assessed Mr Snashfold again on 20 September and his breathing and coughing had improved. He was prescribed naproxen (a painkiller) for his back pain. On 27 September, a GP reviewed Mr Snashfold who said his cough had improved since he had taken the antibiotics.
22. At approximately 12.30am on 28 September, two prisoners found Mr Snashfold collapsed on the floor outside their cell. They heard that he was panicking and struggling to breathe and left their rooms to check on him. The residential block was locked during the evening, but they were not locked in their individual cells as they had shared facilities. They told the investigator that they pressed the emergency alarm to seek staff assistance.
23. Officer A told the investigator that Officer B radioed and asked him to attend the houseblock so that he could respond to the alarm. Officer B said that he was monitoring CCTV on the houseblock as part of his night duty when he heard the alarm. He waited until he could be accompanied by another officer as the prison

was in patrol state. Approximately 5 minutes after the alarm was pressed, both officers found Mr Snashfold in distress and struggling to breathe. Staff encouraged Mr Snashfold to calm down and his breathing improved. The officers supported Mr Snashfold back to his room and Officer A called NHS Direct for advice. NHS Direct called for a non-urgent ambulance to attend. The healthcare provision at The Verne is restricted to the hours of 7.30am to 6.00pm every day. There were no healthcare staff in the prison at this time.

24. The ambulance arrived at 4.15am and paramedics took Mr Snashfold to Dorset County Hospital.
25. Mr Snashfold was admitted to Dorset County Hospital and diagnosed with lung cancer. He had surgery to remove a mass from his lung and was discharged back to The Verne on 7 October. He was seen at the respiratory clinic on 15 October. Further investigations were necessary as the type of cancer that he had was rare. No prognosis was given at that time.
26. On 27 October at around 3.50pm, Mr Snashfold was seen by a nurse as he had tightness in his chest and a cough. His NEWS2 Score (a tool to detect acute illness and deterioration) was three. A score of three means that a patient needs to be reviewed by a registered nurse within four to six hours. However, healthcare staff were not present at the prison after 6.00pm and a GP was not at the prison that day. The nurse planned to discuss Mr Snashfold's condition with a GP the next day.
27. On 28 October, wing staff asked the doctor to see Mr Snashfold as he had been unwell overnight and was having breathing difficulties. A prison GP went to visit him on the wing at 11.00am. Mr Snashfold's NEWS2 score was seven. A score of seven or more means that an urgent medical assessment is needed. She called for an emergency ambulance at 11.04am. The ambulance arrived at 11.18am and Mr Snashfold was taken to Dorset County Hospital.
28. Mr Snashfold's condition worsened, and he died on 4 November at Dorset County Hospital from lung cancer.

Post-mortem report

The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Snashfold's cause of death as lung cancer.

Non-Clinical Findings

29. Prison Service Instruction (PSI) 03/2013, *Medical emergency response codes*, says that the Governor must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.
30. Governors are required to have a two-code medical emergency response system based on the instruction. The Verne uses code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red for when a prisoner is bleeding. The control room should call an ambulance immediately when an emergency code is used.
31. On 28 September, two officers found that Mr Snashfold was struggling to breathe. The officers did not call a code blue and instead encouraged Mr Snashfold to calm down before calling NHS direct for advice. We have made recommendations regarding emergency codes following deaths at The Verne in 2020 and 2021. On both occasions the Governor issued a notice and reminder to staff about the need to use codes. It is clear that more needs to be done to address this issue and urge the Governor to consider how else they can resolve this problem. We have made a recommendation.

Clinical Findings

32. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.

Inquest

33. The inquest into Mr Snashfold's death concluded on 17 July 2023, with a verdict of natural causes.

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