Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Bennett, a prisoner at HMP Oakwood, on 25 August 2023

A report by the Prisons and Probation Ombudsman

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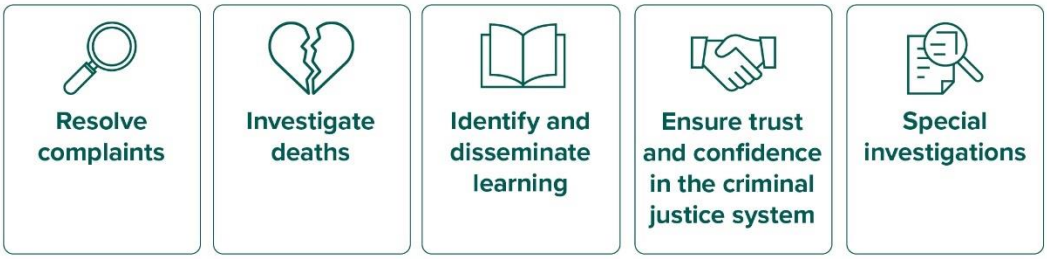
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Carl Bennett died of heart failure caused by ischaemic cardiomyopathy (a decrease in the ability of the heart to pump blood) on 25 August 2023, while a prisoner at HMP Oakwood. He was 54 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Bennett received at Oakwood was equivalent to that which he could have expected to receive in the community.

5. The clinical reviewer made five recommendations not directly related to Mr Bennett's death which the Head of Healthcare will wish to address. She identified areas of good practice, including additional safeguards that were put in place during Mr Bennet's final days at Oakwood, when he initially refused to attend hospital for potentially life-saving treatment.

6. When Mr Bennett was admitted to hospital in June and July 2023, he was inappropriately restrained. His advanced heart failure and failing health was not properly considered.

Recommendation

- The Operational Security Group Director at HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient and outpatient appointments), including at HMP Oakwood, and discuss the findings with the Ombudsman.

- NHS England and the Welsh Government should develop national guidance for establishments to develop local standard operating procedures for healthcare input in the use of force/restraints risk assessments. This guidance should also include roles & responsibilities of healthcare during and post planned and unplanned use of force/restraints.

The Investigation Process

7. HMPPS notified us of Mr Bennett's death on 26 August 2023.

8. NHS England commissioned an independent clinical reviewer to review Mr Bennett's clinical care at HMP Oakwood.

9. The PPO investigator investigated the non-clinical issues relating to Mr Bennett's care.

10. The PPO family liaison officer wrote to Mr Bennett's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

11. We shared the initial report with the Prison Service. There were two factual inaccuracies in the initial report and four factual inaccuracies in the clinical review.

Previous deaths at HMP Oakwood

13. There were ten deaths from natural causes at Oakwood in the three years before Mr Bennett's death, three of which were as a result of COVID-19. There was also a drug related death and a death following a cell fire. Up to March 2024, there have been three further deaths due to natural causes. Our investigation into the death of a man in January 2022 found that restraints were inappropriately used on an older prisoner who was in poor health.

Key Events

14. On 10 February 2016, Mr Carl Bennett was remanded to HMP Hewell for assault. On 17 November, he was sentenced to 13 years in prison.

15. On 17 January 2020, Mr Bennett was transferred to HMP Oakwood.

16. Mr Bennett had decompensated (severe) heart failure and a history of heart attack, a stroke, and a collapsed lung.

17. On 23 January 2023, a GP at Oakwood carried out Mr Bennett's annual heart failure review. After reviewing his blood tests, a GP at Oakwood concluded that the results were satisfactory and as expected and that no further action was needed.

18. At 3.10am on 18 June, prison staff radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) because Mr Bennett said that he had chest pain. A nurse sent Mr Bennett to hospital because he was struggling to breathe and had a productive cough. In hospital, Mr Bennett declined to have blood tests. Hospital staff thought that he had left ventricular failure (left sided heart failure). Hospital staff recommended that he be prescribed furosemide (diuretic medication used to remove a build-up of fluid). Prison staff completed an escort risk assessment before Mr Bennett left for hospital and concluded that Mr Bennett should be restrained using single handcuffs. (When 'single handcuffs' are used on an escort, this means that a standard pair of handcuffs are used to handcuff the prisoner to an escorting officer.) The medical section of the risk assessment was not completed. On 19 June, Mr Bennett went back to Oakwood.

19. That same morning, a Healthcare Assistant (HCA) saw Mr Bennett and noted that he was clammy, disorientated and had a sore throat. A prison paramedic and a GP at Oakwood reviewed Mr Bennett and suspected that he had a chest infection. Mr Bennett refused to go back to hospital, despite the GP explaining that he might die if he did not accept treatment for his heart failure.

20. On 26 June, a GP at Oakwood saw Mr Bennett, who had shortness of breath and a wheeze when breathing. Mr Bennett agreed to go to hospital to stabilise his worsening heart failure, and the GP called a medical emergency code blue. While waiting for the ambulance healthcare staff gave Mr Bennett oxygen.

21. Before Mr Bennett went to hospital, prison staff completed an escort risk assessment. A First Line Manager (FLM) noted that Mr Bennett was a medium risk to the public, a low risk to hospital staff and a low risk of escape. A paramedic completed the medical section and did not object to the use of restraints. A senior manager authorised that two officers escort Mr Bennett and that he be restrained with single cuffs.

22. In hospital, Mr Bennett had an ECG and blood tests. When Mr Bennett had a chest X-ray the officers who were with him obtained permission from a senior manager to remove the restraint. The manager authorised that the restraint could be removed for any further treatment. On 28 June, the officers replaced the single cuff with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer), following authorisation from a manager. On 11 July, Mr Bennett discharged himself from hospital.

23. Healthcare staff tried to persuade Mr Bennett to go back to hospital where he was being treated for decompensated heart failure (a worsening of heart failure symptoms).

24. On 26 July, a nurse saw Mr Bennett and noted that he had swelling to both of his legs and below the waist. That afternoon a nurse noted that Mr Bennett had considerable swelling on his legs and genital area. The nurse noted that Mr Bennett's National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 7 (which indicated a high clinical risk) and sent him to hospital by ambulance.

25. Before he went to hospital, prison staff completed an escort risk assessment. A security manager completed the escort risk assessment and noted that Mr Bennett was a medium risk to the public, a low risk to hospital staff and a low risk of escape. A paramedic completed the medical section, did not object to the use of restraints and noted that Mr Bennett was mobile and independent. The duty director authorised that Mr Bennett be restrained with an escort chain. In hospital Mr Bennett continued to be restrained with an escort chain.

26. On 10 August, despite hospital staff advising him to remain in hospital, Mr Bennett discharged himself and he went back to Oakwood. A prison paramedic saw Mr Bennett and noted that he had a NEWS score of 10 and was extremely clinically unwell.

27. On 12 August, after Mr Bennett's health deteriorated further, healthcare staff successfully persuaded him to go to hospital. When he went to hospital he was not restrained. On 25 August, Mr Bennett died in hospital.

28. There was no post-mortem examination. A hospital doctor concluded that Mr Bennett died of heart failure caused by ischaemic cardiomyopathy (a decrease in the ability of the heart to pump blood).

Findings

Restraints, security and escorts

29. 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. 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 suffering from a serious medical condition. It said 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.

30. Mr Bennett was a 54-year-old man, who had a history of poor health including heart and lung conditions. By June 2023, hospital staff said that he had heart failure.

31. In June 2023, Mr Bennett was twice sent to hospital in a medical emergency. On both occasions he was restrained with a single cuff. On the first occasion, the medical section of the escort risk assessment was not completed, and there is not therefore any evidence that his condition, including struggling to breathe, was considered when judging whether to use restraints. On the second occasion, a nurse completed the medical section but did not object to the use of restraints despite him having shortness of breath that required oxygen. In hospital, prison staff were given permission to remove the restraints for tests, but they were reapplied despite his ongoing periods of breathlessness.

32. On 26 July, when Mr Bennett was sent back to hospital, he was restrained with an escort chain. The same nurse again completed the medical section of the escort risk assessment and did not object to the use of restraints and noted that he was mobile and independent. That morning, before he went to hospital, the medical records show that Mr Bennett had swelling to both of his legs and below the waist and later in the day that he had considerable swelling of his legs and his genital area and that his clinical observations showed that he was a high clinical risk.

33. Mr Bennett's symptoms and medical history on each of these occasions, in line with the High Court judgement, meant that his risk could have been effectively managed by the officers accompanying him without the use of restraints.

34. Following the death of a prisoner in January 2022, we recommended that the Director write to the Ombudsman to explain what further steps he would take to ensure that ill prisoners were not inappropriately restrained. The Director wrote that he and the Head of Healthcare had briefed all managers undertaking the completion of risk assessments to remind them that all relevant information, including health information, should be considered. Nevertheless, Mr Bennett was restrained despite being subject to emergency hospital admissions. We make the following recommendation:

The Operational Security Group Director at HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient and outpatient appointments), including at HMP Oakwood, and discuss the findings with the Ombudsman.

35. We frequently raise concerns about how well healthcare staff understand, or feel empowered, to make a meaningful contribution to the risk assessment process, such as in this case. We make the following recommendation:

NHS England and the Welsh Government should develop national guidance for establishments to develop local standard operating procedures for healthcare input in the use of force/restraints risk assessments. This guidance should also include roles & responsibilities of healthcare during and post planned and unplanned use of force/restraints.

Adrian Usher
Prisons and Probation Ombudsman **May 2024**

Inquest

36. The inquest into Mr Bennett's death was held on 1 July 2024 and a verdict of natural causes was recorded.

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