

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Carlton Bennett a prisoner at HMP Birmingham on 8 July 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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 Carlton Bennett died on 8 July 2016 of heart disease, while at HMP Birmingham. Mr Bennett was 46 years old. I offer my condolences to Mr Bennett's family and friends.

I am satisfied that Mr Bennett received a good standard of clinical care for the short time he was at Birmingham. The post-mortem found Mr Bennett had heart disease, which was not known before he died. He was also a heavy drinker and smoker, and had high blood pressure. All of these conditions were managed appropriately. I am also satisfied that staff acted appropriately during the emergency response. I am satisfied that there is nothing healthcare staff could have done to predict or prevent his sudden death.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**January 2017**

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# Summary

## Events

1. On 1 July 2016, Mr Carlton Bennett was remanded to HMP Birmingham charged with driving offences. A nurse assessed Mr Bennett and he told her that he drank alcohol on a daily basis. She referred him to the Integrated Drug Treatment Service (IDTS). Mr Bennett also told the nurse that he took mirtazapine for depression. Later that day, a prison GP assessed Mr Bennett and prescribed mirtazapine, and diazepam for anxiety.
2. On 2 July, a prison GP recorded Mr Bennett's high blood pressure and prescribed vitamins to assist with his alcohol withdrawal. On 4 July, a nurse again recorded Mr Bennett's high blood pressure, and risk of hereditary heart disease and stroke. Mr Bennett was a heavy smoker and declined smoking cessation advice.
3. An IDTS nurse assessed Mr Bennett on 7 July, and noted that he felt well and was not experiencing any symptoms of alcohol withdrawal.
4. On 8 July, at approximately 8.45am, Mr Bennett told the officer carrying out routine checks that he wanted to stay in his cell and sleep. At approximately 10.00am, a nurse arrived at Mr Bennett's cell to take his blood pressure. Mr Bennett's cellmate told the nurse that Mr Bennett was sleeping. The nurse continued to the next cell.
5. At approximately 12.25pm, Mr Bennett's cellmate noticed that he was not breathing and called for help. The officer who had checked on Mr Bennett that morning responded and found Mr Bennett unresponsive. The officer immediately sought assistance from two officers and at 12.30pm one of them called a code blue emergency (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties). The second officer could not find Mr Bennett's pulse and noted that he was cold to the touch.
6. Healthcare staff responded to the code blue and carried out cardiopulmonary resuscitation until a paramedic arrived. The paramedic pronounced Mr Bennett dead at 12.43pm.

## Findings

7. We are satisfied that Mr Bennett received a good standard of health care at Birmingham, equivalent to that he could have expected to receive in the community. Mr Bennett was promptly referred to the IDTS for his alcohol withdrawal, and his high blood pressure was monitored appropriately. We are also satisfied with the actions taken by staff during the emergency response. Mr Bennett's death was sudden and healthcare staff at Birmingham could have done nothing to prevent it.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Birmingham on 13 July 2016. She obtained copies of relevant extracts from Mr Bennett's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Bennett's clinical care at the prison.
11. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Bennett's daughter to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked us to clarify how Mr Bennett's blood pressure was treated, and to provide a chronology of his health leading up to his death.
13. Mr Bennett's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## **Background Information**

### **HMP Birmingham**

15. HMP Birmingham is a local prison, principally serving the West Midlands courts, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services.

### **HM Inspectorate of Prisons**

16. The most recent inspection of HMP Birmingham was in March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. All prisoners received an initial health screening in reception and a follow up assessment, and GPs in the community were contacted at the beginning of a prisoner's custody to ensure continuity of care. An introductory leaflet about health services was given to prisoners on most wings. The inspectors noted a wide array of nurse-led primary care and lifelong conditions clinics and GP surgeries. Onsite nurses were available out of hours and GPs were on call.

### **Independent Monitoring Board**

17. 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 June 2016, the IMB reported that, on arrival, all prisoners are screened by NHS nurses for physical and mental health issues, and attend a Wellman Clinic within 24 hours. The report noted that there continues to be a generally high level of prisoner satisfaction with healthcare provision.

### **Previous deaths at HMP Birmingham**

18. Mr Bennett is the fourth prisoner to die from natural causes since January 2014. There have been two other deaths since. There are no significant similarities with the circumstances of the previous deaths.

## Key Events

19. On 1 July 2016, Mr Carlton Bennett was remanded to HMP Birmingham, charged with driving offences.
20. The same day, a nurse assessed Mr Bennett during his reception health screening. Mr Bennett told her that he took mirtazapine for depression and drank alcohol daily. She referred Mr Bennett to a prison GP and the Integrated Drug Treatment Service (IDTS). On the same day, a prison GP prescribed mirtazapine and diazepam for depression and anxiety.
21. A prison GP locum examined Mr Bennett on 2 July. He recorded a blood pressure reading of 149 /110. A blood pressure reading greater than 140 / 90 is considered high. The doctor prescribed thiamine and vitamin B to aid Mr Bennett's alcohol withdrawal and detoxification.
22. On 4 July, a nurse recorded Mr Bennett's blood pressure reading as 141/106. the nurse noted that he was at risk of hereditary heart disease and stroke and smoked 40 cigarettes per day. Mr Bennett declined smoking cessation advice.
23. On 6 July, a nurse recorded Mr Bennett's blood pressure reading as 160/116. She noted that he would be referred to a prison GP in two days if it did not improve.
24. The following day, an IDTS healthcare assistant, assessed Mr Bennett. He told her that he felt well and she noted that he had no visible sweats or tremors, was sleeping and eating well, and had not experienced any seizures or blackouts. The IDTS healthcare assistant recorded his blood pressure as 136/111, which although still high was lower than it had been.

### Events of 8 July 2016

25. On 8 July, an officer was unlocking cells and checking on the welfare of prisoners. At 8.45am, he opened Mr Bennett's cell and asked if he wanted to come out for association. Mr Bennett told the officer that he wanted to sleep.
26. At approximately 10.00am, a nurse went to Mr Bennett's cell to review his blood pressure. Mr Bennett's cellmate told the nurse that Mr Bennett was sleeping. The nurse said that he would return later.
27. At approximately 12.25pm, Mr Bennett's cellmate alerted the officer from earlier that Mr Bennett was not breathing. The officer responded immediately and saw Mr Bennett unresponsive in his bed. The officer ran to another officer located on the landing above. A third officer followed them back to Mr Bennett's cell. One of the officers could not locate Mr Bennett's pulse and felt his body was cold and stiff. He immediately called a code blue (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties) over the radio, at 12.30pm.
28. Two nurses responded to the code blue, and went to Mr Bennett's cell. A third nurse joined them. The nurses could not locate a pulse on Mr Bennett. One of the nurses started cardiopulmonary resuscitation and another nurse went to get the defibrillator (a life-saving device that gives the heart an electric shock in some

cases of cardiac arrest), located on the adjoining wing. The nurses applied the defibrillator to Mr Bennett which advised no shock. Two nurses continued with CPR.

29. There were already two paramedics treating a less critically ill prisoner within the prison. One of the paramedics went to Mr Bennett's cell, examined Mr Bennett's body, and instructed the nurses to stop cardiopulmonary resuscitation. The paramedic pronounced Mr Bennett dead at 12.43pm.

### **Contact with Mr Bennett's family**

30. At 1.13pm, the prison appointed an officer as a family liaison officer.
31. Mr Bennett's partner was his next of kin. The family liaison officer with two senior managers, arrived at the home of Mr Bennett's partner at 3.40pm that day, to inform her of Mr Bennett's death. There was no response, so they then went to the home of Mr Bennett's ex-partner and daughters. The family liaison officer told them that Mr Bennett had died, and offered his condolences and ongoing support.
32. The family liaison officer tried to contact his partner after this, and managed to make contact for the first time on 11 July. Mr Bennett's daughters had already informed his partner of his death. The family liaison officer maintained telephone contact with both Mr Bennett's partner and a daughter.
33. Mr Bennett's funeral was held on 11 August. The prison contributed towards the costs in line with national policy.

### **Support for prisoners and staff**

34. After Mr Bennett's death, the Director 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.
35. The prison posted notices informing other prisoners of Mr Bennett's 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 Bennett's death.

### **Post-mortem report**

36. The post-mortem concluded that Mr Bennett died from heart disease.

## Findings

### Clinical care

37. Mr Bennett had been at Birmingham for seven days when he died. In his first few days, healthcare assessments identified high alcohol and cigarette consumption, high blood pressure, and a family history of heart disease and stroke. An IDTS worker assessed Mr Bennett promptly. He declined smoking cessation advice, and his blood pressure was monitored on a daily basis.
38. The clinical reviewer considered that the IDTS worker assessed Mr Bennett in line with the prison's drug and alcohol strategy, which follows local and national guidelines. (Prison Service Order (PSO) 3550 Clinical Services for Substance Misusers; and PSO 3630 Counselling, Assessment, Referral, Advice and Throughcare Services.) Healthcare staff regularly monitored Mr Bennett's blood pressure, with a planned GP review after one week. The clinical reviewer considered that this was appropriate, as it gave them time to consider treatment on top of other treatment Mr Bennett was already receiving.
39. The investigation found that there was no evidence that Mr Bennett suffered from symptoms of heart disease, or complained of any symptoms to healthcare staff, in the week before he died. We are satisfied that the prison healthcare team monitored Mr Bennett appropriately in his short time at Birmingham. Mr Bennett's death was sudden and unexpected and there was nothing that healthcare staff could have done to prevent it. His care was equivalent to that he could have expected to receive in the community.

### Emergency response

40. The officer that responded to the cell mate's request for help, was a new member of staff. When he found Mr Bennett unresponsive, he alerted experienced officers. The officer said that it took ten seconds to reach the other officer and return to Mr Bennett's cell, at which point the third officer joined them and called a code blue. The prison's local emergency response protocol states that "when a member of staff on scene discovers a potentially life threatening health related scenario, they must use the Code Red or Code Blue prefix over the radio net or telephone system".
41. The prison told us that radios are not issued to every prison officer, and that on 8 July, it was highly unlikely that the new officer had a radio in order to transmit a code blue. The officer should have located the nearest telephone in line with local protocol. However, on this occasion, the short duration from discovering Mr Bennett to a code blue being called did not cause a delay to the emergency response or affect the outcome for Mr Bennett. We are satisfied that prison staff responded appropriately.

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