

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Cecil Benfold a prisoner at HMP High Down on 13 January 2018

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 Cecil Benfold died of bronchopneumonia on 13 January 2018 while a prisoner at HMP High Down. He was 92 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare Mr Benfold received at High Down was good and equivalent to that which he could have expected to receive in the community.

However, I am concerned that when Mr Benfold went back to High Down from the hospital on 9 January, a prison GP did not add his anticipatory medicine to the nursing chart, and this meant that nursing staff were unable to give him further pain relief.

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

June 2018

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Summary

Events

The diagnosis of Mr Benfold's terminal illness and informing him of his condition

1. On 20 July 2017, Mr Cecil Benfold was sentenced to four years and six months in prison for sex offences and was sent to HMP High Down.
2. On 20 July, at his initial health assessment, a nurse noted that Mr Benfold was frail, walked with a stick and was breathless after walking. He said that he had heart failure and an irregular heart rhythm, for which he had a pacemaker fitted.
3. On 22 July, at a second health screen, a nurse was unable to complete a full assessment of Mr Benfold's health and medication needs because he did not have his community medical records. The community medical records did not arrive until 6 October.
4. Mr Benfold lived in the prison's inpatient unit where staff monitored him. He had social care and assistance with his daily routines.
5. On 20 August, a nurse gave Mr Benfold his medication in his cell, and noted swelling to both lower legs. She booked an appointment for him to see a GP. A prison GP saw Mr Benfold the next day, asked for blood tests and gave him a diuretic (water tablet). The blood tests showed that he had mild kidney disease and mild anaemia.
6. On 14 September, a prison GP reviewed Mr Benfold and asked for more blood tests because he also had a slightly abnormal liver function test.
7. On 28 September, a prison GP saw Mr Benfold, who said he did not want life-prolonging treatment or to be resuscitated if his heart or breathing stopped.
8. On 30 December, a prison GP saw Mr Benfold and said that he had peripheral oedema (fluid in the tissues of the lower limbs). Healthcare staff noted that Mr Benfold was getting weaker. He had cellulitis (a skin infection) which worsened the next day, and he went to hospital. No other formal diagnosis was made.

Mr Benfold's clinical care

9. In hospital, Mr Benfold had a CT scan (an imaging procedure that uses x-rays to create detailed scans), started receiving intravenous antibiotics, had a catheter fitted and received end-of-life care which outlined his needs holistically, observing his dignity and respecting his wishes. Hospital staff stopped all treatment and medication, except for pain relief medication. On 9 January 2018, Mr Benfold was returned to High Down.
10. On 11 January, Mr Benfold coughed up some blood. A nurse did not give pain relief anticipatory medication (medication given by nursing staff to a patient who is dying who becomes stressed or has pain) because it had not been added to the nursing chart by a prison GP for her to administer. She asked for an ambulance. The paramedics who attended said that Mr Benfold was dying and

moving him to hospital might cause a cardiac arrest. He did not go to hospital and healthcare staff continued to monitor him.

11. Mr Benfold died on 13 January. A post-mortem examination established the cause of his death as bronchopneumonia. He also had general frailty, generalised oedema (body swelling), heart failure, chronic obstructive pulmonary disease and narrowing of the arteries.

Findings

12. We are satisfied that the healthcare Mr Benfold received at High Down was good and equivalent to that which he could have expected to receive in the community. When it was clear that Mr Benfold was nearing the end of his life, healthcare staff spoke to Mr Benfold and his family about his needs, dignity and respect during his final days.
13. However, when Mr Benfold was in distress on 11 January, he could not be given his anticipatory pain relief medication. If a prison GP had added the medication advised by hospital staff to the nursing chart for nursing staff to administer, Mr Benfold's additional distress might have been avoided.

Recommendations

- The Head of Healthcare should ensure that all anticipatory medicine is promptly added to a prisoner's nursing chart so it can be administered.

The Investigation Process

14. The investigator, issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact him. No one responded
15. The investigator obtained copies of relevant extracts from Mr Benfold's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Benfold's clinical care at the prison.
17. We informed HM Coroner for Surrey of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
18. The investigator wrote to Mr Benfold's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
19. The investigation has assessed the main issues involved in Mr Benfold's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP High Down

21. HMP High Down is a local prison in Surrey, which at the time of Mr Benfold's death, held up to 1,150 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

22. The most recent inspection of High Down was in January 2015. Inspectors reported that overall, health services were good but staff shortages resulted in too many cancelled appointments. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments. Inspectors considered this good practice.

Independent Monitoring Board

23. 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 December 2017, the IMB said that the cancellation of outpatient clinics had reduced considerably due to the recruitment of many uniformed staff. The inpatient unit with 23 beds had been full for most of the year due in part to prisoners with challenging behaviour being assessed for possible transfer to mental health facilities.

Previous deaths at HMP High Down

24. There have been ten previous deaths at High Down since January 2015, nine of which were from natural causes. There were no significant similarities between the deaths.

Findings

The diagnosis of Mr Benfold's terminal illness and informing him of his condition

25. On 20 July 2017, Mr Cecil Benfold was sentenced to four years and six months in prison for sex offences and was sent to HMP High Down.
26. At his initial health assessment, a nurse saw Mr Benfold who was frail, walked with a stick and became breathless after taking a few paces. He said that he had heart failure and an irregular heart rhythm for which he had a pacemaker fitted. He had cataracts in both eyes, was deaf and wore hearing aids. Mr Benfold said that he had depression and used antidepressants.
27. On 22 July, a nurse completed a second health screen. He did not have Mr Benfold's community medical records so was unable to fully assess his health and medication needs. Despite regular requests from healthcare staff, the community medical records did not arrive until 6 October. When they arrived, prison GPs adjusted his medication.
28. A nurse sent Mr Benfold to the prison's inpatient unit and planned for staff to monitor him for physical decline, to note his observations daily, to refer him to social care and to assist him in his daily routines. She asked for a GP to review him.
29. On 26 July, a member of staff from the adult social care prison team saw Mr Benfold. She noted that he could get out of bed but he became short of breath after little effort. She referred him to the physiotherapy and occupational health teams. On 9 August, a physiotherapist, saw Mr Benfold who refused the use of a Zimmer frame and said that he would continue to use his stick.
30. On 20 August, a nurse saw Mr Benfold in his cell when she gave him his medication. She noted that he had swelling to both lower legs. She booked an appointment for Mr Benfold to see a GP.
31. On 21 August, a prison GP, saw Mr Benfold. She asked for blood tests and gave him a diuretic (water tablet). The blood tests showed that he had mild kidney disease and mild anaemia.
32. On 1 September, a prison GP, saw Mr Benfold for a review. He noted that his main problem was heart failure and added him to the list to review the disease.
33. On 2 September, a nurse gave Mr Benfold an extra pillow to keep him upright in bed to allow him to breathe easier. She planned to weigh him regularly and noted that he risked retaining water because of his heart failure. She noted that his mood was low and asked him to go to group therapy sessions which he attended on 5 September.
34. On 14 September, a prison GP, reviewed Mr Benfold and asked for more blood tests because he had mild chronic kidney disease and a slightly abnormal liver function test.
35. On 19 September, Mr Benfold moved from the inpatient unit to a standard cell on a wing. The next day, a member of the adult social care team, saw Mr Benfold

and said that the occupational health team should assess him before he could stay on the wing so he moved back to the inpatient unit.

36. On 27 September, a member of staff from the adult social care prison team, saw Mr Benfold with an occupational therapist who noted that he was very short of breath after little effort, and that he had swollen ankles. Mr Benfold said that he was not taking his water tablets because they made him go to the toilet often. The occupational therapist arranged for him to have a commode and a head rest so that he could sit more upright and asked a GP to review him.
37. On 28 September, a prison GP saw Mr Benfold who told her that he was near to the end of his life. She noted that Mr Benfold did not want life-prolonging treatment and said that he did not want to be resuscitated if his heart or breathing stopped. She told Mr Benfold to take his water tablets, gave him antibiotics for a possible chest infection and asked for more blood tests.
38. On 1 October, a nurse reviewed Mr Benfold's care plan. She noted that Mr Benfold had facial swelling, his shortness of breath had worsened and he needed more assistance with his daily routines. She noted that Mr Benfold was being nursed in a hospital bed. On 4 October, she completed a falls assessment.
39. On 4 November, because Mr Benfold was refusing to take some of his medication, a prison GP, noted that Mr Benfold appeared to have full mental capacity. He told him about the risks of not taking his medication.
40. On 9 December, a prison GP saw Mr Benfold in his cell and noted that his health was slowly declining. Mr Benfold had oedema due to fluid retention, he was distressed and wheezing and had a low body temperature which improved during the day.
41. On 24 December, a nurse went to Mr Benfold's cell because she heard him screaming. He told her that he was trying to get out of his wheelchair and slipped. He said that the pain in his right leg was getting worse. The nurse did a new falls risk assessment.
42. On 30 December, a prison GP saw Mr Benfold and noted that he had peripheral oedema (swelling due to fluid in the tissues of the lower limbs). He noted that he was refusing his medication. Healthcare staff noted that Mr Benfold was getting weaker, had cellulitis (a skin infection) which worsened the next day, and needed to go to hospital.
43. Nursing staff and auxiliary staff were timely in seeing new symptoms in Mr Benfold such as his body swelling and shortness of breath. Mr Benfold did not always take his medication so a prison GP reviewed his mental capacity and prison GPs encouraged him to take his medication. When a prison GP saw that Mr Benfold had a skin infection, he was sent to hospital in a timely manner.
44. Mr Benfold died on 13 January. A post-mortem examination established the cause of his death as bronchopneumonia. He also had general frailty, generalised oedema, congestive heart failure, chronic obstructive pulmonary disease and cerebrovascular disease.

Mr Benfold's clinical care

45. While Mr Benfold was in hospital, healthcare staff frequently contacted the hospital to obtain updates about Mr Benfold's condition and treatment. In hospital, Mr Benfold had a CT scan, intravenous antibiotics, a catheter and received end of life care. Hospital staff stopped all treatment and medication, except for pain relief medication. On 9 January 2018, Mr Benfold went back to High Down. When he left hospital, he was given anticipatory pain relief medication.
46. On 10 January, a nurse completed an end-of-life care plan, including to address how to meet Mr Benfold's physical, psychological, social, spiritual needs and privacy would be met.
47. On 11 January, Mr Benfold coughed up some blood. A nurse was unable to give pain relief medication because a prison GP had not added his anticipatory medication to the nursing chart for her to administer. She asked for an ambulance. The paramedics who attended said that Mr Benfold was dying and moving him to hospital might cause him a cardiac arrest. Healthcare staff continued to monitor him.
48. At 5.52pm on 13 January, an officer was with Mr Benfold in his cell and saw that he was no longer breathing. He told two nurses who confirmed that he was dead.
49. We are satisfied that overall, the healthcare Mr Benfold received at High Down was good and equivalent to that which he could have expected to receive in the community. When it was clear that he was nearing the end of his life, healthcare staff spoke to Mr Benfold and his family and appropriately talked to them about his needs, dignity and respect.
50. However, on 11 January, when Mr Benfold was in distress, he could not be given his anticipatory medication because a prison GP had not added it to the nursing chart. Qualified nursing staff can give palliative care medications if they are written up correctly and clearly. This needs clear, timely communication between secondary care, prison GPs, and nursing staff. If the prison GP had clearly added the medication advised by hospital staff for nursing staff to administer, Mr Benfold's additional distress could have been avoided. We make the following recommendation:

The Head of Healthcare should ensure that all anticipatory medicine is promptly added to a prisoner's nursing chart so it can be administered.

Mr Benfold's location

51. On 9 January, Mr Benfold was returned to High Down and went to the inpatient unit.
52. On 10 January, a member of staff spoke to a nurse consultant at the hospice, to see if there was a bed for Mr Benfold. On 11 January, a nurse spoke to the nurse consultant at the hospice. They planned to discuss Mr Benfold at a community meeting the next day but she said there were currently no beds available at two hospices. A bed did not become available and Mr Benfold remained at High Down.

53. We are satisfied that Mr Benfold was appropriately located. When he went back to High Down he went to the inpatient unit. Healthcare made appropriate attempts to find a bed at a local hospice.

Restraints, security and escorts

54. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
55. When Mr Benfold went to hospital on 30 December, healthcare staff noted on the escort risk assessment that restraints should not be used because he was elderly and medically unwell. The Head of Safer Custody, authorised the use of a single cuff but because Mr Benfold's wrists were swollen, she was satisfied that officers should not restrain him.
56. Although we query the decision to use a single cuff, we consider it appropriate, given Mr Benfold's condition and the implications for his risk, that he was not restrained when he was going to hospital or subsequently.

Liaison with Mr Benfold's family

57. On 8 January 2018, High Down appointed a senior officer, as the family liaison officer (FLO). She telephoned Mr Benfold's son and told him that he was in hospital, was returning to High Down and was having palliative care. The FLO asked Mr Benfold's son if he would like to visit him at the prison.
58. On 9 January, Mr Benfold's wife, son and sister-in-law visited him in hospital because he had not returned to High Down.
59. On 11 January, the FLO telephoned Mr Benfold's wife because he was seriously ill. She arranged for the family to visit Mr Benfold at High Down which they did later that day.
60. After Mr Benfold died, the Head of Security, telephoned his wife and told her that he had died. The FLO telephoned Mr Benfold's son and told him he had died. They offered their condolences.
61. The FLO remained in contact with Mr Benfold's wife and family. Mr Benfold's funeral took place on 12 February. The prison contributed to the cost in line with national instructions.

Compassionate release

62. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months.
63. A safer custody hub manager, said there was no application for compassionate release because Mr Benfold's health deteriorated very quickly. She said that

although he was receiving palliative care when he returned from hospital, he did not have a formal terminal diagnosis or clear prognosis. He died three days later.

64. We are satisfied that Mr Benfold did not have a prognosis of less than three months and that it was therefore reasonable within the provisions of the compassionate release policy that staff did not start the compassionate release process for him.

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