

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Shaun Bennett a prisoner at HMP Northumberland on 9 March 2019

**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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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 Shaun Bennett died in hospital on 9 March 2019 from kidney failure while a prisoner at HMP Northumberland. He was 52 years old. I offer my condolences to Mr Bennett's family and friends.

Mr Bennett was taken to hospital on 3 March after reporting diarrhoea and vomiting. Hospital doctors diagnosed him with a perforated gall bladder, but decided that it was too high risk to operate because Mr Bennett had liver failure. Mr Bennett deteriorated rapidly and died in hospital a week later.

The investigation found that overall, the care Mr Bennett received at Northumberland was equivalent to that which he could have expected to receive in the community. However, there was a delay in sending Mr Bennett to hospital because the nurse initially requested a non-urgent ambulance rather than an emergency one, although the clinical reviewer was satisfied that the delay did not affect the outcome for Mr Bennett.

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 2019**

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# Summary

## Events

1. On 18 July 2018, Mr Shaun Bennett was remanded in custody for threats to kill and being in possession of a weapon. He was sent to HMP Durham.
2. On 18 February 2019, Mr Bennett was moved to HMP Northumberland. He had several health conditions including cirrhosis of the liver (where the liver does not function properly), caused by long-term alcohol abuse. He was prescribed appropriate medication.
3. On the morning of 3 March, Mr Bennett told staff that he had been suffering with diarrhoea and vomiting during the night, and had abdominal pain. A nurse saw him later that morning and advised him to rest and drink plenty of fluids. When the nurse returned to see him at about 3.00pm, she noted that his blood pressure was very low. She sought advice from a senior nurse, who in turn sought advice from a doctor. The doctor advised that Mr Bennett needed to go to hospital. The nurse requested a non-emergency ambulance.
4. At around 4.50pm, the nurse assessed Mr Bennett again and noted that his blood pressure had fallen further. She upgraded the ambulance to an emergency one.
5. Mr Bennett was taken to hospital and diagnosed with a perforated gall bladder. Hospital doctors decided he was too high risk to be operated on because he had liver failure. He deteriorated rapidly and died on 9 March.
6. The post-mortem report concluded that Mr Bennett died from kidney failure, caused by a perforated gall bladder and alcoholic cirrhosis.

## Findings

7. The clinical reviewer found that overall, Mr Bennett's care was equivalent to that which he could have expected to receive in the community.
8. However, the clinical reviewer was concerned that the nurse did not respond correctly to Mr Bennett's clinical deterioration when she assessed him at 3.00pm. The nurse recorded that Mr Bennett's blood pressure scored 3 using the National Early Warning Score (NEWS) tool. Guidance says that if a person has a NEWS score of 3 in a single parameter, an urgent medical review should take place and hourly observations should be undertaken. The nurse should have called an emergency ambulance at the outset and observed Mr Bennett at least hourly. She did not assess him again for almost two hours. The clinical reviewer was satisfied, however, that the delay did not affect the outcome for Mr Bennett.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of the National Early Warning Score (NEWS) guidance, and that it is used consistently to help assess and monitor prisoners with acute symptoms.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Bennett's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Bennett's clinical care at the prison.
12. We informed HM Coroner for Northumberland of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Bennett's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
14. The initial report was shared with the Prison Service. The Prison Service identified a point for clarification regarding the cause of a previous death. This did not affect the factual accuracy of our report and we have not made any amendments.

# Background Information

## HMP Northumberland

15. HMP Northumberland holds up to 1,348 men. Sodexo Justice Services manage the prison and G4S provide the healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm from Monday to Thursday and from 7.30am to 6.00pm on Friday. At weekends and on bank holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out of hours service at other times.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements. They said that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, inspectors found that most healthcare needs were met. They said that medical incidents occurred regularly, many connected to the use of psychoactive substances (PS). Inspectors said that most prison officers had received appropriate first aid training and had access to defibrillators.

## 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.
18. In its latest annual report, for the year to 31 December 2018, the IMB reported that GP waiting times continued to fluctuate during the year, with a peak of 36 days in July and August. The Board considered the failure to deliver consistent service to be unacceptable.

## Previous deaths at HMP Northumberland

19. Mr Bennett was the eighth prisoner to die at Northumberland since March 2017. Of the previous deaths, four were from natural causes, one was self-inflicted, one was drug-related and one had an unknown cause of death. There have been no deaths since. There were no similarities between Mr Bennett's death and previous deaths at Northumberland.

## Key Events

20. On 18 July 2018, Mr Shaun Bennett was remanded in custody for threats to kill and being in possession of a weapon. He was sent to HMP Durham. On 8 February 2019, he was sentenced to two years imprisonment.
21. On 18 February, Mr Bennett was moved to HMP Northumberland. A nurse completed his first night assessment and noted that he had several long-term health conditions, including high blood pressure and cirrhosis of the liver (a condition where the liver does not function properly), caused by long-term alcohol abuse. He was prescribed appropriate medication.
22. On 3 March at 9.00am, when Mr Bennett went to collect his medication, he told a nurse that he had had diarrhoea and sickness since 3.00am. She told him that if it got worse he should contact healthcare staff.
23. At 10.45am, a prison officer called the nurse and asked her to attend Mr Bennett's cell as he was feeling unwell and had abdominal pain. The nurse gave him some painkillers and took his observations. His blood pressure was low at 102/56 (a normal blood pressure would be between 120/80 and 140/90). He had a National Early Warning Score (NEWS) of 3, with the blood pressure element scoring 1. (NEWS is a tool used to assess clinical deterioration in adults. It allocates a score of 0-3 for each vital sign: respiratory rate; oxygen saturation level; pulse; blood pressure; temperature; and level of consciousness. The scores are added together to give an overall score. Patients with a total score of 1-4 should be assessed by a health professional who decides on frequency of monitoring and whether care needs to be escalated. Where any vital sign scores 3, then the patient requires an urgent medical review in an acute setting, and hourly observations.)
24. The nurse recorded that Mr Bennett's blood pressure was likely to be low due to dehydration following episodes of diarrhoea and sickness. She advised Mr Bennett to drink as much water as possible and said she would review him again in a few hours.
25. At 3.00pm, the nurse went back to see Mr Bennett, who said that he still had abdominal pain which was now going up into his shoulder blades. The nurse also noted that his blood pressure had dropped further and his score for blood pressure was 3 using the NEWS tool. She contacted the senior nurse on duty to ask for advice. He contacted the out of hours GP who said that Mr Bennett needed to go to hospital. The nurse requested a non-urgent ambulance. She did not stay with Mr Bennett while waiting for the ambulance.
26. At approximately 4.50pm, the nurse reviewed Mr Bennett again. She noted that his blood pressure was still very low at 72/52 and he was still in pain. She called the ambulance control to upgrade the ambulance to urgent. She stayed with Mr Bennett until the ambulance arrived at 5.25pm.
27. Mr Bennett was taken to Northumbria Specialist Emergency Care Hospital, escorted by two prison officers who used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer and the other to the prisoner.) Mr Bennett was admitted to

hospital and diagnosed with a perforated gall bladder. He was transferred to a high dependency unit.

28. On 4 March, when prison healthcare staff called the hospital for an update on Mr Bennett's condition, they were told that he was too high risk for surgery because he had liver failure, so there was nothing further that they could do. A do not attempt cardiopulmonary resuscitation (DNACPR) order was put in place. Prison healthcare staff regularly kept in touch with the hospital and visited Mr Bennett to offer support.
29. On 6 March, it was noted that Mr Bennett was receiving palliative care only. He had declined an application for release on compassionate grounds as he did not have a suitable address to be released to. Instead the hospital discussed Mr Bennett's suitability for a transfer to either HMP Holme House or a Marie Curie hospice for end of life care.
30. On 8 March, it was agreed that Mr Bennett would be transferred to the Marie Curie hospice. However, during the transfer he became very unwell and had to be returned to the hospital. His condition rapidly deteriorated and he died on 9 March at 6.30pm.

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

31. On 4 March, when Mr Bennett's condition deteriorated, the prison appointed a family liaison officer (FLO). He contacted Mr Bennett's sister that day and informed her that Mr Bennett had been taken to hospital.
32. The FLO offered ongoing support to Mr Bennett's family at the hospital, and after Mr Bennett's death. The prison paid for the funeral in line with national guidelines. The funeral took place on 22 March.

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

33. After Mr Bennett's death, a prison manager debriefed the staff involved in Mr Bennett's care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
34. The prison posted notices informing other prisoners of Mr Bennett's death, and offered 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**

35. The post mortem report concluded that Mr Bennett died of acute kidney failure, caused by a perforated gall bladder and alcoholic cirrhosis (where the liver does not function properly because of long-term damage from alcohol).

# Findings

## Clinical care

36. The clinical reviewer considered that the care Mr Bennett received at Northumberland was equivalent to that which he could have expected to receive in the community.
37. However, the clinical reviewer was concerned that when Mr Bennett became unwell on 3 March, healthcare staff did not follow the NEWS clinical guidance. When Mr Bennett's vital signs were measured, his blood pressure scored a 3 (on a scale of 0 to 3). Guidelines state that a prisoner with a single parameter NEWS score of 3, should have an urgent medical review with a clinician and hourly assessments. The clinical reviewer considered that the nurse should have called an emergency ambulance rather than a non-urgent one. She also noted that the nurse did not assess Mr Bennett again for almost two hours.
38. Although the clinical reviewer considered that the delay in sending Mr Bennett to hospital did not change the outcome for him, it is important that prison healthcare staff know how to use the NEWS tool and that they respond appropriately if clinical deterioration is identified. Therefore, we make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff are aware of the National Early Warning Score (NEWS) guidance, and that it is used consistently to help assess and monitor prisoners with acute symptoms.**

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