

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Lenyn Knapton, a prisoner at HMP North Sea Camp, on 12 August 2020

**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 Lenyn Knapton died in Peterborough City Hospital on 12 August 2020 of a stroke at while a prisoner at HMP North Sea Camp. Mr Knapton was 80 years old. I offer my condolences to Mr Knapton's family and friends.
4. On 8 August, Mr Knapton had been taken to hospital after being found unresponsive on the floor of his room. As it was a weekend, there were no healthcare staff on duty in the prison at the time. The clinical reviewer commended prison staff for the speed with which they recognised that Mr Knapton may have had a stroke and for taking prompt action to request an ambulance.
5. However, she concluded that the clinical care Mr Knapton received at North Sea Camp was not equivalent to that which he could have expected to receive in the community. She made three recommendations to the Head of Healthcare. She also made recommendations to enhance the prison's response in future medical emergencies, which we have reflected in this report.
6. We found that the prison took more than seven hours to contact Mr Knapton's next of kin when he had become seriously ill and was taken to hospital by emergency ambulance on 8 August 2020. We make one recommendation.
7. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendations

- **The Governor should:**
  - **share the learning about the early recognition of Mr Knapton's symptoms with staff generally; and**
  - **promote a stroke recognition tool such as FAST (together with the Head of Healthcare).**
- **The Governor should ensure that procedures are in place to enable staff to relay a prisoner's symptoms to the ambulance service as promptly as possible, to help with appropriate triage by the ambulance service.**
- **The Head of Healthcare should ensure there is an effective process in place:**

- for the monitoring of abnormal blood pressures in line with NICE hypertension guidance; and
  - for recalling prisoners with known or suspected cardiovascular disease.
- The Head of Healthcare and lead GP should jointly ensure that there is an effective process in place for reviewing and acting upon hospital outpatient letters, to facilitate continuity of care.
  - The Head of Healthcare should share the findings of this report and the clinical review with the healthcare team for reflection and learning.
  - The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Knapton's clinical care at HMP North Sea Camp.
9. A PPO investigator has investigated non-clinical issues, including Mr Knapton's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Knapton's next of kin, his partner, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

## Background

### Previous deaths at HMP North Sea Camp

12. Mr Knapton was the sixth prisoner to die at North Sea Camp since August 2018. Of the previous five deaths, four were from natural causes and one was a drug related death. Since Mr Knapton's death, there has been one death from natural causes.

## Key Events

13. On 10 December 2010, Mr Lenyn Knapton was sentenced to 15 years imprisonment for sexual offences. He was sent to HMP Leeds.
14. On 15 August 2018, Mr Knapton arrived at HMP North Sea Camp on transfer from HMP Whatton. At his reception health screening his blood pressure was slightly raised. In line with expected practice, three further blood pressure checks took place. His pulse rate was within the normal range, but was irregular. An ECG (a heart trace) was performed which detected some abnormalities. Mr Knapton was referred for assessment by a cardiologist.
15. Mr Knapton attended a cardiology appointment on 24 January 2019. The diagnosis given on the hospital letter identified an unusual/extra noise made by the heart and an abnormal heartbeat rhythm. Mr Knapton was not experiencing any cardiac symptoms at that time.
16. A consultant cardiologist offered further investigations which Mr Knapton declined. As a result, he was discharged from their services but was told that he could be re-referred should he wish. No recommendations were made to the prison GPs about medication or ongoing monitoring.
17. On 31 January, Mr Knapton attended an older adult assessment with prison healthcare and his blood pressure and heart rate were taken. There was no recorded assessment of follow-up appointments to monitor his blood pressure which was above the normal range.
18. On 20 March 2020, Mr Knapton's parole hearing scheduled for 7 April was cancelled due to the COVID-19 pandemic. On 5 April, in response to the COVID-19 pandemic, Mr Knapton was invited to move onto the shielding unit in the prison, given his age and health. He declined and signed a disclaimer to that effect.
19. On 29 June, Mr Knapton attended the healthcare unit because he had a sore throat. Healthcare staff gave him appropriate advice. His blood pressure and heart rate were checked and were raised. There is no evidence in Mr Knapton's medical notes of any ongoing monitoring, and no further appointments were arranged.
20. On 20 July, Mr Knapton attended his rearranged parole hearing. On 23 July, the Parole Board directed that Mr Knapton should be released. This meant that he would be released from prison, subject to an appeal against the decision by the Ministry of Justice (MoJ) on behalf of the Secretary of State. The MoJ had 21 days in which to lodge an appeal.
21. On 8 August, around 2.40pm, another prisoner, found Mr Knapton unresponsive on the floor of his room. Mr Knapton had last been seen around an hour before. A prisoner alerted an officer at 2.44pm. The officer immediately radioed an emergency code blue (indicating a prisoner is unconscious or having breathing difficulties). Staff in the communications room immediately telephoned for an ambulance. Prison staff used an office phone to tell the Ambulance Service that they suspected Mr Knapton had had a stroke. An ambulance arrived at the

prison at 3.19pm. Paramedics assessed Mr Knapton and took him to Peterborough City Hospital, leaving the prison at 3.46pm.

22. The ambulance arrived at Peterborough City Hospital at 4.33pm. A CT scan showed that Mr Knapton had had a stroke caused by a blood clot (an ischemic stroke). Attempts were made to dissolve the clot by means of thrombolysis (use of 'clot-busting' medication). Thrombolysis was administered around 5.35pm and was within the 4.5-hour post stroke window needed for the medication to have greatest effectiveness.
23. That evening, around 11.00pm, the Night Orderly Officer (the officer in charge of the prison overnight) contacted Mr Knapton's next of kin to tell them that Mr Knapton had had a suspected stroke and was in hospital.
24. Hospital doctors continued to treat Mr Knapton. On the evening of 9 August, they advised the prison's escorting officers that Mr Knapton's prognosis was poor. They asked that the prison inform his next of kin.
25. In the early hours of 10 August, doctors told the escorting officers that Mr Knapton had a bleed on his brain that could not be operated upon. Doctors spoke to his family to advise them of the situation. Later in the day, medical staff began palliative care for him.
26. On the same day, a Senior Probation Officer emailed the Ministry of Justice and the Parole Board and asked them to consider early release on compassionate grounds (a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired), given Mr Knapton's poor health and the Parole Board's direction to release Mr Knapton. Mr Knapton died before a final decision was made.
27. On the evening of 10 August, Mr Knapton's family visited him in hospital. They visited again on 11 August.
28. On 12 August, at 9.28am Mr Knapton died at Peterborough City Hospital.

### **Post-mortem report**

29. The Coroner concluded that Mr Knapton died from a cerebral infarction (a stroke) and cerebrovascular disease (a group of conditions that affect blood vessels in the brain). He also had atrial fibrillation (a condition which can cause an irregular and often abnormally fast heart rate) and ischaemic heart disease which did not cause but contributed to his death.

## Non-Clinical Findings

### Liaison with Mr Knapton's family

30. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner's health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted.
31. On 8 August when staff found Mr Knapton unresponsive in his cell, they suspected he had had a stroke. They rightly called an emergency ambulance immediately, and staff waited with Mr Knapton until the paramedics arrived.
32. The ambulance left the prison at 3.46pm. Mr Knapton's family were not contacted until 11.13pm – around seven and a half hours after the ambulance left. It was clear that Mr Knapton was seriously ill, and we consider that there was too long a delay in contacting Mr Knapton's family to inform them he was ill and had been taken to hospital.
33. However, we acknowledge that once appointed on the morning of 9 August, the Family Liaison Officers (FLOs) provided timely information and support to Mr Knapton's family prior to and after his death. We make the following recommendation:

**The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

**Elizabeth Moody**

**Prisons and Probation Deputy Ombudsman**

**April 2021**

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