

Prisons &
Probation

Ombudsman
Independent Investigations

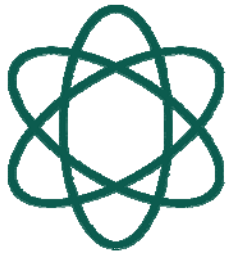
Independent investigation into the death of Mr Allan Benton, a prisoner at HMP Wymott, on 15 November 2021

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

OGL

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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 Allan Benton died in hospital of heart disease on 15 November 2021, while a prisoner at HMP Wymott. He was 78 years old. We offer our condolences to Mr Benton's family and friends.
4. The clinical reviewer concluded that most aspects of the healthcare Mr Benton received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community. However, she made several recommendations on aspects that she considered fell below a satisfactory standard. We list the relevant recommendations below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that if a care plan prescribes a course of action, such as recording the prisoner's weight regularly, then this is carried out and documented in the SystemOne record.
- The Head of Healthcare should ensure that a falls risk assessment (and falls risk assessment management plan) are updated in the SystemOne record following an incident where a person has fallen irrespective of injury.
- The Head of Healthcare should consider the use of the multifactorial falls risk assessment (CG161) for when a person presents with multiple falls or injury from falling.
- The Head of Healthcare should ensure that a complete set of neurological observations (Glasgow Coma Scale) is taken when a person has fallen and sustained an injury to the head.
- The Head of Healthcare should ensure that prisoners who score 82 or below in an Addenbrookes Cognitive Examination (ACE iii) are referred to a memory clinic or if no referral is made, that staff record their rationale.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Benton's clinical care at HMP Wymott.
7. The PPO investigator has investigated non-clinical issues, including Mr Benton's location, the security arrangements for his hospital escorts and liaison with his family.
8. One of the PPO's family liaison officers wrote to Mr Benton's next of kin, his daughters, to explain the investigation. One asked for a copy of our report but did not have any questions for us to consider. The other did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy which we have amended in this report. The action plan is annexed to this report.
10. We sent a copy of our initial report to Mr Benton's daughter. She did not respond.

Previous deaths at HMP Wymott

11. Mr Benton was the 17th prisoner to die at Wymott since November 2019. Of the previous deaths, 15 were from natural causes and one was drug related. There are no similarities between our findings from our investigation into Mr Benton's death and the investigation findings from the previous deaths.

Key Events

12. In June 2015, Mr Allan Benton was sentenced to 13 years and six months in prison for sexual offences. He was moved to HMP Wymott on 7 December 2020.
13. Mr Benton had multiple health conditions including asthma, borderline chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), hypertension (high blood pressure), peripheral vascular disease (PVD - a blood circulation disorder which causes the blood vessels outside of the heart to become narrow or blocked), osteoarthritis (a condition which causes joints to become stiff and painful) and leg ulcers (long-lasting sores).
14. Staff put appropriate care plans in place for Mr Benton's medical conditions and changed the dressings on his leg ulcers every few days. They also put in place a social care package to help Mr Benton with his personal care needs. Initially Mr Benton was not allowed to keep his medication in his possession due to memory problems but in May 2021, staff decided that he could keep his medication in possession and that social care workers would support him to take it twice daily.
15. Mr Benton was obese. Despite healthcare staff noting that he should have his weight recorded monthly, this was not done.
16. Mr Benton also had very poor mobility and had frequent falls. Staff put in place a falls risk assessment, but this was not always reviewed and updated after each fall.
17. On 16 June 2021, a mental health nurse completed an Addenbrookes Cognitive Examination (ACE iii) on Mr Benton to assess his cognitive ability given concerns about his memory. Mr Benton scored 82 out of 100 (a score of 82 or below indicates likely dementia). The nurse recorded that Mr Benton's score did not merit a referral to a memory clinic at that time, which was incorrect.
18. On 23 October, Mr Benton tested positive for COVID-19 as part of mass screening on his wing. He had no symptoms initially and isolated in his cell.
19. On 24 October, a prison nurse saw Mr Benton to change the dressings on his leg ulcers. The nurse raised a concern about Mr Benton's increasing frailty, inability to transfer himself and disorientation. The prison GP advised that Mr Benton should be taken to A&E for further investigation. The prison arranged transport to take Mr Benton to A&E.
20. While in hospital Mr Benton had a CT scan and received antibiotics for an infection in his leg ulcer. He returned to Wymott on 8 November.
21. On the morning of 10 November, a nurse went to Mr Benton's cell to review his leg dressings and found him mumbling. She described him as 'vacant' and thought he could be dehydrated. The nurse discussed Mr Benton's presentation with the GP who agreed that Mr Benton could be dehydrated but was also concerned that he might have an infection. The GP asked healthcare staff to call an ambulance to take Mr Benton to A&E for further assessment.
22. Mr Benton was taken to hospital that afternoon and was given intravenous fluids. He was returned to Wymott in the early hours of 11 November.

23. On 13 November, a nurse went to Mr Benton's cell to change his leg dressings and found he was drowsy and mumbling his words. Mr Benton said he felt weary and unwell. The nurse had to help him take his medication.
24. Later that day, prison officers asked healthcare staff to see Mr Benton after he fell from his chair and hit his head. After taking Mr Benton's clinical observations, healthcare staff asked for an ambulance to be called to take Mr Benton to hospital. (The clinical reviewer noted that staff did not record a Glasgow Coma Score (used to assess the patient's level of consciousness) as they should have done.)
25. Mr Benton was admitted to hospital and treated for a chest infection.
26. At 6.55am on 15 November, Mr Benton died in hospital.

Post-mortem report

27. The post-mortem report concluded that Mr Benton died of ischaemic heart disease. It listed hypertension as a contributory factor. The report noted that Mr Benton had tested negative for COVID-19 on 13 November. COVID-19 was not listed as either a cause of death or a contributory factor.

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