

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

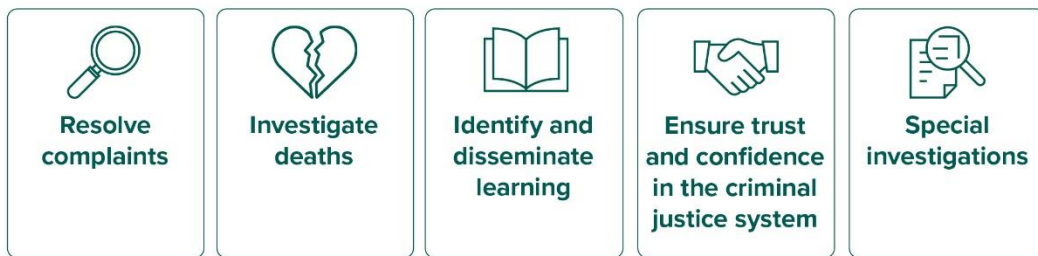
# **Independent investigation into the death of Mr Gene Benjamin, a prisoner at HMP Wakefield, on 11 February 2022**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Gene Benjamin died of end stage heart failure on 11 February 2022 at HMP Wakefield. He was 64 years old. We offer our condolences to Mr Benjamin's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Benjamin received at Wakefield was equivalent to what he could have expected to receive in the community. The clinical reviewer made recommendations about communication arrangements between the prison and the hospital, DNACPR training for prison staff, appropriate end of life counselling support and timely reviews of treatments for long term conditions, which we do not repeat in this report, but which the Head of Healthcare will need to address.
5. The prison did not provide an alternative named contact when the prison's family liaison officer was on leave and did not explain the constraints of the prison regime when the family wanted to arrange a visit.

## Recommendations

- The Prison Group Director should reassure themselves that HMP Wakefield has a robust system in place for providing a Family Liaison service throughout the year that can withstand the, predictable, absence of a single individual.
- The Governor and the Head of Healthcare, when making arrangements for family members to spend time with dying prisoners that go beyond normal measures, should explain to the family the constraints of the prison regime.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Benjamin's clinical care at Wakefield.
7. The PPO investigator investigated the non-clinical issues relating to Mr Benjamin's care. The investigation was then transferred to one of the investigator's colleagues.
8. The PPO family liaison officer wrote to Mr Benjamin's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Benjamin's sister said that the family were very distressed that they had been unable to visit Mr Benjamin having been told he was dying. Mr Benjamin's sister said that they had telephoned Wakefield several times and left messages, but no one returned their calls. We address this concern in our report.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. The action plan has been annexed to this report.
10. We sent a copy of our initial report to Mr Benjamin's family. They did not notify us of any factual inaccuracies.

## Previous deaths at HMP Wakefield

11. Mr Benjamin was the 31<sup>st</sup> prisoner to die at Wakefield since February 2019. Of the previous deaths, 28 were from natural causes and three were self-inflicted.
12. In a previous investigation into the death of a prisoner at Wakefield in February 2019, we recommended that the prison ensure that families who wanted to visit dying prisoners understood the constraints of the prison regime. The prison accepted our recommendation and said that they had put measures in place to prevent this happening again in future. It is disappointing that we are raising this issue again in this report.

## Key Events

13. On 1 July 2010, Mr Gene Benjamin was remanded to HMP Dorchester, charged with sexual and violent offences. On 12 December 2012, he was sentenced to life in prison, with a tariff of 11 years. He was 55 years old. Mr Benjamin transferred to HMP Wakefield on 25 August 2011.
14. Mr Benjamin had several long-term health conditions, including type 2 diabetes, kidney problems, joint and muscle problems, an underactive thyroid and a range of heart related conditions (for which he was fitted with both a pacemaker and an internal cardiac defibrillator to regulate his heart's performance). Mr Benjamin also needed, and was provided with, appropriate care for a range of other health conditions.
15. On 19 June 2020, the clinical team at the prison reviewed Mr Benjamin's case. The outcome of the review was that Mr Benjamin's conditions were at an advanced stage and he was expected to live for only a few months.
16. On 3 December, an emergency ambulance took Mr Benjamin to Pinderfields Hospital Accident and Emergency after he presented with dehydration, seeming confused and disoriented and with a swollen lower abdomen. The hospital discharged Mr Benjamin on 7 December, with the plan that he received an increased dose of prednisolone for two days.

## 2021

17. For much of January 2021, Mr Benjamin reported feeling generally unwell and highlighted persistent tiredness as an issue. Blood results showed an ongoing steady decline of his kidney function. Mr Benjamin's presentation worsened on 3 February, and a GP at the prison decided that Mr Benjamin needed to be taken to hospital via emergency ambulance, due to the complexity of his multiple conditions.
18. Mr Benjamin tested positive for COVID-19 on 4 February. The hospital diagnosed pneumonia and a collapsed right lung. He received intravenous antibiotics and the hospital inserted a chest drain to help manage the pneumonia symptoms. During this admission, and following discussion with hospital staff, Mr Benjamin consented to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, meaning that, in the event his heart or breathing stopped, he would not be resuscitated.
19. Having returned to Wakefield and recovered, Mr Benjamin discussed the DNACPR order with a GP at the prison. On 14 April, Mr Benjamin's status changed to reflect that the clinical team would attempt resuscitation if his heart stopped.
20. On 9 December, Mr Benjamin attended hospital for a cardiology review. The hospital admitted him for further tests. The results indicated that Mr Benjamin's heart failure condition remained fairly stable, but there was a deterioration in his kidney function. The hospital identified Mr Benjamin as having acute kidney injury stage 3. This level meant that Mr Benjamin's likely risk of experiencing further complications, without urgent treatment, was at its highest. Mr Benjamin remained in Pinderfields Hospital until they stabilised his conditions. The hospital discharged Mr Benjamin on 17 December.

21. On 26 December, Mr Benjamin's condition deteriorated again, with shortness of breath, tiredness, elevated breathing rate and lowered blood oxygen levels. An emergency ambulance took Mr Benjamin to hospital. Following assessment in Accident and Emergency, Mr Benjamin returned to Wakefield on the afternoon of 27 December.

## **2022**

22. On 10 January 2022, the prison assigned a Family Liaison Officer (FLO).
23. On 12 January, Mr Benjamin said he did not wish anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. Mr Benjamin also agreed to the deactivation of the defibrillation function of his implanted cardiac device.
24. On 18 January, Mr Benjamin underwent a planned medical procedure in Pinderfields Hospital, to disable the defibrillator function of his pacemaker. The hospital prescribed end of life medications and Mr Benjamin was referred for a mental health review.
25. On 1 February, a nurse at Wakefield reviewed Mr Benjamin's end of life care plan, with a further review planned for 15 February.

## **Events of 11 February 2022**

26. At around 4.07pm on 11 February, an officer found Mr Benjamin unresponsive in his cell. Not knowing Mr Benjamin had a DNACPR order in place, the officer called a code blue (indicating a prisoner is unconscious or is having breathing difficulties), and control room staff called an ambulance. The officer did not attempt CPR.
27. When healthcare staff attended the cell, they stood down the ambulance after confirming the DNACPR order. Healthcare staff contacted the out of hours GP service and asked for a doctor to attend to certify the death. A doctor attended and certified Mr Benjamin's death at 8.27pm.
28. The prison's FLO promptly informed Mr Benjamin's sister of his death.

## **Record of Inquest**

29. On 14 March 2022, the inquest concluded that Mr Benjamin died of end stage heart failure, with cardiac sarcoid and chronic kidney disease.

## Non-Clinical Findings

### Liaison with Mr Benjamin's family

30. Mr Benjamin's family raised concerns about the quality of liaison they received from Wakefield before Mr Benjamin died. Prison Service Instruction (PSI) 64/2011, says that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.
31. The appointed family liaison officer explained that having been appointed on 10 January 2022, they then had a period of leave that month. On 27 January, the FLO recorded in the log that Mr Benjamin's partner and sister had contacted them the previous week, while they were on leave, and that they had now returned the call. The FLO told Mr Benjamin's family how to book visits through the normal visits booking system.
32. The FLO next contacted Mr Benjamin's partner on 8 February. The FLO had no record of any missed calls to them or messages for them during this time. On 10 February, Mr Benjamin changed his next of kin to his sister. The FLO recorded that they planned to contact Mr Benjamin's sister outside of her work hours, to discuss arranging a visit. On 11 February, Mr Benjamin died before any arrangements could be made.
33. The FLO explained that, following Mr Benjamin's medical procedure on the 18 January, his prognosis was improved and while he was considered to be terminally ill, he was well enough to attend the visits hall and so his family were expected to book visits in the normal way. The FLO explained that, in certain circumstances (normally when a prisoner is too ill to leave their cell, or considered to be very close to death), family visits can be arranged outside the normal processes, but that did not apply at the time in Mr Benjamin's case.
34. From the information provided, it appears that Mr Benjamin's family did contact the prison during the time the FLO was on leave. They then had to wait until the FLO returned from leave to contact them.
35. Following an investigation into a death in Wakefield in 2019, we recommended that the Governor should ensure that when a FLO takes leave, they hand over their FLO responsibilities to another suitable member of staff and inform the family of the new contact details. We also recommended that the Governor and the Head of Healthcare, when making arrangements for family members to spend time with dying prisoners that goes beyond normal measures, should explain to the family the constraints of the prison regime. The prison accepted both recommendations. They said that a designated family liaison officer manager would oversee the family liaison process, including when liaison responsibilities needed to be passed from one FLO to another. The prison also said that families would be provided with a clear explanation of prison restrictions and constraints so that they could easily understand what sort of arrangements were possible.
36. In Mr Benjamin's case, there is no evidence that the prison provided the family and next of kin with an alternative named contact during the FLO's leave period. Nor did

we see evidence that the constraints of the prison regime were explained to the family in respect of arranging a visit. We make the following recommendations:

**The Prison Group Director should reassure themselves that HMP Wakefield has a robust system in place for providing a Family Liaison service throughout the year that can withstand the, predictable, absence of a single individual.**

**The Governor and the Head of Healthcare, when making arrangements for family members to spend time with dying prisoners that go beyond normal measures, should explain to the family the constraints of the prison regime.**

**Adrian Usher  
Prisons and Probation Ombudsman**

**October 2023**

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