

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Roalfe, a prisoner at HMP Channings Wood, on 20 November 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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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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 William Roalfe died in hospital of bronchopneumonia on 20 November 2021, while a prisoner at HMP Channings Wood. Mr Roalfe was 66 years old. I offer my condolences to Mr Roalfe's family and friends.

The clinical reviewer found that the care Mr Roalfe received at Channings Wood was only partly equivalent to that which he could have expected to receive in the community. She noted that Mr Roalfe had complex health needs and was seen frequently by healthcare staff. However, some opportunities were missed to provide him with all the care and support he needed, particularly with his nutritional needs and concerns about his mental capacity and self-neglect.

I am concerned that the prison was unable to provide some of the documentation requested for this investigation.

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

November 2022

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Summary

Events

1. Mr William Roalfe was recalled to prison on 20 August 2020. He was moved to HMP Channings Wood on 10 October.
2. Mr Roalfe had chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases) and limited mobility. There was also a concern that he might have early signs of dementia, but he was never diagnosed.
3. In June 2021, Mr Roalfe complained of chest pains. He refused to attend two chest X-ray appointments in June and July but attended on 19 August. The X-ray showed that part of Mr Roalfe's lung was enlarged. A letter was sent to Mr Roalfe's GP advising that this needed to be investigated further.
4. On 20 August, a prison GP noted that Mr Roalfe had not collected his in-possession medication from the pharmacy. The GP arranged for Mr Roalfe's medication to be dispensed at the medication hatch instead to try to improve his compliance. The GP also noted that Mr Roalfe needed to take nutritional supplements due to significant weight loss.
5. On 21 September, a prison GP noted that Mr Roalfe had not had a further X-ray and asked for this to be chased up. (He did not have another X-ray before he died.)
6. In late October, Mr Roalfe complained of feeling weak. A nurse reviewed him and found that he had low blood pressure. The next day, he still had low blood pressure, so a nurse made a GP referral. There is no record the GP saw him.
7. By November, Mr Roalfe was lying in bed most of the time. He was also refusing to collect his medication. He had ongoing weight loss. A nurse noted uneaten food in his cell and that he needed help to sit up and drink.
8. On 8 November, Mr Roalfe was taken to hospital and diagnosed with a urinary tract infection (UTI). He was returned to Channings Wood that evening.
9. On 13 November, a nurse asked for an ambulance as Mr Roalfe's condition was deteriorating and he was showing signs of sepsis. Mr Roalfe refused to go to hospital that day and the next day.
10. On 15 November, Mr Roalfe agreed to go to hospital. He was admitted and treated for pneumonia and malnourishment. Mr Roalfe did not recover and died on 20 November.

Findings

11. The clinical reviewer found that the care Mr Roalfe received at Channings Wood was only partly equivalent to that which he could have expected to receive in the community.
12. The clinical reviewer noted that Mr Roalfe had complex health needs and could sometimes be challenging to manage. She also noted that healthcare staff saw him frequently. However, she identified some areas for improvement, particularly around

onward referrals and monitoring, assessing his mental capacity and managing his self-neglect.

13. The clinical reviewer was concerned about entries made in the medical record that 'orders' were given by prison staff so that Mr Roalfe could be moved from his bed and washed. Prison staff deny that an order would have been given to move Mr Roalfe out of his bed against his will, but this is what the HCA seemed to have understood. Staff need to understand their lawful authority to move prisoners and when decisions in their best interests can be made under the Mental Capacity Act.
14. The prison was unable to provide the PPO with the escort risk assessment for Mr Roalfe's final transfer to hospital.

Recommendations

- The Head of Healthcare should ensure that:
 - there are clear processes and pathways in place to enable staff to make timely onward referrals; and
 - staff use appropriate clinical assessment and monitoring tools.
- The Head of Healthcare should ensure that all healthcare staff receive training on the Mental Capacity Act and that staff know when and how to assess mental capacity.
- The Head of Healthcare should ensure that healthcare staff are compliant in the correct level of safeguarding training in accordance with their roles as set out in the Royal College of Nursing (RCN) Intercollegiate Document for 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018).
- The Head of Healthcare should ensure the local operating policy for managing omitted doses of medication is reviewed and includes more specific and clearer guidance to the Pharmacy Team on the management (including when to alert the GP) of in-possession medication that has not been collected.
- The Head of Healthcare should ensure that healthcare staff follow the protocols for clinical escalation as per NEWS2 and sepsis pathways.
- The Governor and Head of Healthcare should:
 - review the two incidences in November 2021 where the HCA thought that prison staff gave her authority to move Mr Roalfe out of bed; and
 - identify what training is needed so there is clear understanding of the lawful authority of prison staff, and when the Mental Capacity Act should be used instead, or in parallel.
- The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
16. The investigator obtained copies of relevant extracts from Mr Roalfe's prison and medical records.
17. NHS England commissioned an independent clinical reviewer to review Mr Roalfe's clinical care at the prison.
18. We informed HM Coroner for Plymouth of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. The Ombudsman's family liaison officer contacted Mr Roalfe's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Channings Wood

21. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Practice Plus Group Health and Rehabilitation Services Limited provides healthcare services. The healthcare services are commissioned to be on site from 7.30am to 6.30pm during the week, and between 7.30am and 5.30pm on the weekend. Mental health care is provided by Devon Partnership NHS Trust.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Channings Wood was in September 2018. Inspectors reported that some efforts had been made to improve standards since their last inspection in October 2016, but they were not coordinated, and previous HMIP recommendations had not been implemented. Inspectors assessed the prison outcomes as not sufficiently good in all four areas of their healthy prisons tests – safety, respect, purposeful activity, and rehabilitation and release planning.
23. In relation to healthcare, inspectors reported that local clinical governance systems were not driving improved outcomes for patients. Primary care staffing was stretched and not always able to meet demand. An independent health complaints system had been introduced but many complaints had not been responded to and a backlog had developed. Responses were not always adequate.
24. In July 2019, HMIP conducted an Independent Review of Progress (IRP) at Channings Wood. Inspectors reported that the overall governance of healthcare had improved. Partnership, contracts and local delivery board meetings were robust and well supported by the NHS England commissioner. There was a much-improved process for raising concerns or complaining about health services; more recent changes to the process needed more time to embed.

Independent Monitoring Board

25. 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 31 August 2020, the IMB reported that healthcare provision at Channings Wood was generally of an equivalent standard to that received in the wider community. They reported that staff responded effectively to COVID-19 infections in the prison and had put appropriate measures in place to cope with the restricted regime.

Previous deaths at HMP Channings Wood

26. Mr Roalfe was the seventh prisoner to die at Channings Wood since November 2019. Of the previous deaths, one was self-inflicted and five were from natural causes. There are no similarities between our findings from our investigation into Mr Roalfe's death and our findings from the previous deaths.

Key Events

27. In January 2011, Mr William Roalfe was sentenced to 12 years in prison for sexual offences. He was released on licence in December 2019.
28. On 20 August 2020, Mr Roalfe was recalled to prison because of poor behaviour. He was moved to HMP Channings Wood on 10 October.
29. Mr Roalfe had chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases). He had also had a heart attack in 2011. He had reduced mobility.
30. On 16 June 2021, staff found Mr Roalfe on the floor of his cell complaining of chest pains. Staff called for an ambulance. Paramedics performed an electrocardiogram (ECG - a test that checks the heart's rhythm) which was normal. Mr Roalfe remained at Channings Wood.
31. The prison GP visited Mr Roalfe later that day and prescribed painkillers. The GP also requested a chest X-ray (to be done in Channings Wood by a visiting provider). The GP also noted that she would ask the Mental Health Team to assess Mr Roalfe as he might have signs of early dementia. No further assessments were conducted by the GP or Mental Health Team.
32. On 24 June, Mr Roalfe refused to attend for his chest X-ray. It was rearranged for 15 July, but Mr Roalfe again refused to attend.
33. On 5 August, a prison GP prescribed Mr Roalfe with antidepressants due to concerns about his low mood, poor motivation and ongoing pain.
34. On 19 August, Mr Roalfe attended his X-ray, which showed an enlargement at the root of his lung. A letter explaining that this would need further investigation was sent to Mr Roalfe's GP.
35. On 20 August, a prison GP noted that Mr Roalfe had not collected his in-possession medication from the pharmacy. The GP arranged for Mr Roalfe's medication to be dispensed at the medications hatch instead to try to improve his compliance. The GP also noted that Mr Roalfe needed to take nutritional supplements due to significant weight loss.
36. On 22 August, a nurse made a referral to the local council for a social care package. The nurse noted that Mr Roalfe appeared malnourished and needed daily help with personal care. (From 11 November, the council provided a 30-minute visit a day to help Mr Roalfe with personal care.)
37. On 28 August, a nurse noted that Mr Roalfe had a pressure sore (injuries to the skin and underlying tissue caused by prolonged pressure on the skin) on his back, which showed signs of healing and no infection. Healthcare staff reviewed Mr Roalfe's pressure sore regularly, and they encouraged Mr Roalfe to spend less time lying down as the sore was still not healing on 11 September.
38. On 21 September, a prison GP noted that Mr Roalfe had still not had his follow up X-ray and asked an administrator to chase up the appointment.

39. On 24 September, a prison GP reviewed Mr Roalfe due to significant weight loss and his concerns about his chest. The GP requested an urgent chest X-ray. Due to long waiting times, Mr Roalfe did not have another X-ray before he died.
40. On 12 October, a pharmacy technician noted that Mr Roalfe had not been collecting his medication. Mr Roalfe had been storing his medication in his cell, and told staff this was because he was worried, he would not be able to get it at the medication hatch. Healthcare staff decided that Mr Roalfe could not keep his medication in his cell.
41. On 26 October, Mr Roalfe complained of feeling weak with ringing ears. A nurse took his observations and noted he had low blood pressure. The next day, his blood pressure was still low, so a nurse referred him to the GP. On 28 October, a nurse reviewed Mr Roalfe and found he still had low blood pressure. There is no evidence he was seen by the GP in response to the earlier referral.
42. On 2 November, Mr Roalfe complained of a weak left arm and left leg. A nurse sent a task to the GP to review him, but there is no evidence a GP responded.
43. On 3 and 4 November, Mr Roalfe refused to collect his medication. Staff encouraged him to do so. On 4 November, a nurse went to see him, and found that his back had worsened again. The nurse cleaned and dressed the wound. Staff discussed Mr Roalfe at a Multi-Professional Complex Case Clinic (MPCCC) the same day. They noted that Mr Roalfe was lying in bed most of the time which was causing his skin to break down. They also noted that his nutritional supplements needed to be increased due to ongoing weight loss and that he should be weighed weekly.
44. On 6 November, Mr Roalfe told a nurse that he had fallen twice recently. She noted that he was dishevelled but his clinical observations were stable, and he had no apparent injuries.
45. On 7 November, a nurse reviewed Mr Roalfe and found an infected wound on his elbow. The nurse saw that Mr Roalfe had uneaten food in his cell and needed help to sit up and drink. Mr Roalfe began a course of antibiotics.
46. On 8 November, a nurse cleaned and dressed Mr Roalfe's wound. Mr Roalfe had been incontinent of urine, but Mr Roalfe was refusing to stand up to allow his bed to be changed. The nurse asked for a prison paramedic to see Mr Roalfe, who advised that Mr Roalfe should be taken to A&E. Hospital doctors prescribed antibiotics for a urinary tract infection (UTI - an infection in any part of your kidneys, ureters, bladder, or urethra). Mr Roalfe returned to Channings Wood that evening.
47. On 9 November, healthcare staff assessed Mr Roalfe three times, they found he had been incontinent and encouraged him to eat, drink, and get out of bed.
48. On 10 November, two healthcare assistants (HCAs) reviewed Mr Roalfe, who had been incontinent and was refusing to get out of bed. One of the HCAs noted that a prison manager gave a 'prison direct order' to remove Mr Roalfe from his cell in order for him to have a shower. When asked, the manager said he did not give an order to get Mr Roalfe out of bed against his wishes, and that a prison power like that would be inappropriate.

49. On 12 November, an HCA attended Mr Roalfe, as he had been incontinent and was refusing help with his personal care. The HCA documented that with an 'Officer order' Mr Roalfe allowed her to help him wash.
50. On 13 November, an HCA reviewed Mr Roalfe, who was still refusing to get up or cooperate with assistance. The HCA found Mr Roalfe's wounds were not healing and referred him to a nurse. The nurse took Mr Roalfe's observations and expressed concern at his deteriorating condition, as he was showing signs of sepsis.
51. The prison arranged for an ambulance to take Mr Roalfe to hospital, but he refused, saying he would go the next day. On 14 November, Mr Roalfe again refused to go to hospital.
52. On 15 November, healthcare found that the wound on Mr Roalfe's back had got worse and he had a new sore on his knee. Mr Roalfe agreed to go to hospital, where hospital staff admitted him and treated him for pneumonia and malnourishment.
53. Mr Roalfe did not recover and died in hospital on 20 November.

Contact with Mr Roalfe's family

54. On 16 November, the prison appointed an officer as the family liaison officer (FLO). The FLO contacted Mr Roalfe's sister after his death to offer her condolences and support. The prison contributed to the funeral costs in line with policy.

Support for prisoners and staff

55. After Mr Roalfe's death, a prison manager contacted the bedwatch officers present when Mr Roalfe died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Post-mortem report

56. The post-mortem report concluded that Mr Roalfe died of bronchopneumonia.

Findings

Clinical Care

57. The clinical reviewer found that the care Mr Roalfe received at HMP Channings Wood was only partly equivalent to that which he could have expected to receive in the community. She noted that Mr Roalfe had complex health needs, that healthcare staff saw him frequently and that he was challenging to work with at times due to his poor engagement with staff and self-neglect. Nevertheless, there were several areas where care could have been improved.
58. There were delays in referring Mr Roalfe for further investigations following his chest X-ray. Staff did not refer Mr Roalfe for a dementia assessment. The clinical reviewer also found that given his weight loss and nutrition issues, staff should have referred Mr Roalfe to a dietician and also put in place a clinical assessment tool (such as MUST - Malnutrition Universal Screening Tool). We recommend:

The Head of Healthcare should ensure that:

- **there are clear processes and pathways in place to enable staff to make timely onward referrals; and**
- **staff use appropriate clinical assessment and monitoring tools.**

59. The clinical reviewer considered that there were missed opportunities to assess Mr Roalfe's mental capacity. She also found that staff should have considered making a safeguarding referral given Mr Roalfe's self-neglect. We recommend:

The Head of Healthcare should ensure that all healthcare staff receive training on the Mental Capacity Act and that staff know when and how to assess mental capacity.

The Head of Healthcare should ensure that healthcare staff are compliant in the correct level of safeguarding training in accordance with their roles as set out in the Royal College of Nursing (RCN) Intercollegiate Document for 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018).

60. There was also a lack of policy on non-compliance with collecting in-possession medication. We recommend:

The Head of Healthcare should ensure that the local operating policy for managing omitted doses of medication is reviewed and includes more specific and clearer guidance to the Pharmacy Team on the management (including when to alert the GP) of in-possession medication that has not been collected.

61. There were several occasions when staff took Mr Roalfe's clinical observations and calculated a NEWS2 score that was a cause for concern. (NEWS2 is a tool used to assess clinical deterioration in adult patients.) The clinical reviewer considered that Mr Roalfe should have had closer monitoring in response to the NEWS2 scores. We recommend:

The Head of Healthcare should ensure that healthcare staff follow the protocols for clinical escalation as per NEWS2 and sepsis pathways.

62. The clinical reviewer was concerned about entries in the medical records that said 'prison orders' were given to enable Mr Roalfe to be moved from his bed so that he could be washed. Prison staff said that orders would not have been given to move Mr Roalfe against his will, though it appears that this is what the HCA understood. Staff should understand what their lawful authority is to move prisoners and when they can make decisions in the prisoner's best interests in line with the Mental Capacity Act. We recommend:

The Governor and Head of Healthcare should:

- **review the two incidences in November 2021 where the HCA thought that prison staff gave her authority to move Mr Roalfe out of bed; and**
- **identify what training is needed so there is clear understanding of the lawful authority of prison staff, and when the Mental Capacity Act should be used instead, or in parallel.**

Providing evidence to the PPO

63. The prison was unable to provide the PPO with the escort risk assessment for Mr Roalfe's final transfer to hospital on 15 November. From a review of other documentation provided, it appears that he was restrained using an escort chain. As the escort risk assessment was not provided, we cannot check what factors were considered or whether the decision was justified. We are concerned that the prison was unable to produce this document when requested. We recommend:

The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

Inquest

64. The inquest, held on 10 September 2024, concluded that Mr Roalfe died from natural causes.

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