Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Hooper, a prisoner at HMP Channings Wood, on 20 May 2022

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 l 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

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.

Mr John Hooper died from a perforation of a benign gastroduodenal ulcer (an ulcer which occurs in the intestine just beyond the stomach) on 20 May 2022, while a prisoner at HMP Channings Wood. He was 74 years old. I offer my condolences to his family and friends.

The clinical care that Mr Hooper received at Channings Wood was good and equivalent to that which he could have expected to receive in the community.

The emergency response and care provided to Mr Hooper on 20 May was of a high clinical quality.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **June 2023**

Contents

Summary

1. On 13 September 2018, Mr John Hooper was sentenced to 16 years in prison for sex offences. On 17 May 2019, he was transferred to HMP Channings Wood.

2. On 17 May 2022, a nurse saw Mr Hooper because he had stomach pain. He told the nurse that he had had diarrhoea and had been vomiting for twenty-four hours. The nurse noted that Mr Hooper looked well. She asked for a faecal sample, gave him paracetamol, and told him to isolate.

3. On 18 and 19 May, healthcare staff made daily welfare checks but were not concerned about Mr Hooper's presentation. They did not collect the faecal sample and, during a review after Mr Hooper's death, the Primary Care Clinical Lead noted this omission and agreed to implement a process to ensure this happened in future.

Events of 20 May 2022

4. At about 11.00am on 20 May, a healthcare assistant saw Mr Hooper who had been sick, appeared confused and looked pale. Mr Hooper told her that he had stomach pain. She asked an officer to find a nurse.

5. A nurse subsequently went to Mr Hooper's cell and noted that he had a high pulse rate, a high respiratory rate and a low temperature. The nurse noted that Mr Hooper's National Early Warning Score (a tool to detect and respond to clinical deterioration) was 5 which indicated a medium clinical risk. He asked for the emergency nurse to see Mr Hooper and arrange for him to go to hospital.

6. The emergency nurse saw Mr Hooper in his cell. He saw dried blood (indicating blood loss) on Mr Hooper's bed and considered that he was dehydrated. The nurse was unable to obtain a radial pulse (from his wrist) or a blood oxygen saturation reading.

7. At 11.36am, an officer telephoned the ambulance service and explained Mr Hooper's condition.

8. At 12.05pm, an ambulance arrived at Channings Wood and at 12.10pm, paramedics were at Mr Hooper's side. At 12.15pm, Mr Hooper went into cardiac arrest. An officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) and a number of other healthcare staff went to Mr Hooper's cell.

9. Ambulance paramedics and healthcare staff carried out cardiopulmonary resuscitation (CPR).

10. At 12.40pm, ambulance paramedics detected that Mr Hooper had a heartbeat and at 1.17pm, they transferred him to hospital, where he died at 3.38pm that day.

Findings

11. The clinical reviewer concluded that the clinical care that Mr Hooper received at Channings Wood was good and was equivalent to that which he could have expected to receive in the community.

12. The clinical reviewer found many examples of good clinical practice in Mr Hooper's case and found that the healthcare record-keeping on the day he died should be commended as an example of good contemporaneous record-keeping.

13. The clinical reviewer found that the emergency response and care provided to Mr Hooper on 20 May was of a high clinical quality. Good quality life support was given which resulted in the return of a heart rhythm.

14. The clinical reviewer made a recommendation which is not directly related to Mr Hooper's death but which the Head of Healthcare will need to address.

15. We make no recommendations

The Investigation Process

16. 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 him. A prisoner contacted the investigator.

17. The investigator obtained copies of relevant extracts from Mr Hooper's prison and medical records.

18. The investigator interviewed an ex-prisoner on 27 July.

19. NHS England commissioned a clinical reviewer to review Mr Hooper's clinical care at the prison.

20. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The Ombudsman's family liaison officer contacted Mr Hooper's friend, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

22. We shared the initial report with the Prison Service. There were no factual inaccuracies.

23. We shared the initial report with Mr Hooper's friend. There were no factual inaccuracies. Mr Hooper's friend raised a number of concerns relating to Mr Hooper's clinical care, which have been answered by way of separate correspondence.

Background Information

HMP Channings Wood

24. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Practice Plus Group provides healthcare services. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm on weekends. Devon Doctors provides an out-of-hours GP service.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Channings Wood was in July 2022. Inspectors reported that the healthcare team operated independently to prison staff, and a closer working rapport would enhance prisoner care. The healthcare team faced recruitment challenges, which had an impact on existing staff. The department relied heavily on additional hours and agency staff.

26. Inspectors reported that arrangements for providing a rapid and skilled response to medical emergencies were comprehensive. These were overseen by the prison paramedic team. Staff were trained to use immediate life support skills and resuscitation equipment was appropriate and regularly checked. Prison staff provided the first response once the healthcare team had left the site, and most staff had received first aid training and could access automated external defibrillators (AEDs) on the wings.

Independent Monitoring Board

27. 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 August 2022, the IMB reported that despite the high turnover of staff and the challenges presented by COVID-19, a reasonable standard of healthcare services had continued to be delivered.

Previous deaths at HMP Channings Wood

28. There were three deaths from natural causes at HMP Channings Wood in the two years before Mr Hooper’s death, one of which was related to COVID-19. There was one self-inflicted death and a drug-related death. Since Mr Hooper’s death, there has been a further self-inflicted death. There are no significant similarities between our findings in this investigation and those of the other investigations.

Key Events

29. On 13 September 2018, Mr John Hooper was sentenced to 16 years in prison for sex offences. On 17 May 2019, he was transferred to HMP Channings Wood.

30. Mr Hooper had a number of chronic conditions, including chronic obstructive pulmonary disease (COPD, a lung disease) and chronic kidney disease.

31. On 17 July 2021, a nurse reviewed Mr Hooper's COPD care plan and noted that his COPD was stable.

32. On 17 May 2022, Mr Hooper saw a nurse because he had stomach pain. Mr Hooper told her that he had had diarrhoea and had been vomiting for twenty-four hours, that he had not eaten but had drunk plenty of fluids. She noted that Mr Hooper looked well. She asked him for a faecal sample, gave him paracetamol and told him to isolate.

33. On 18 and 19 May, healthcare staff made daily welfare checks but had no concerns about Mr Hooper's presentation. Healthcare staff did not collect the faecal sample. (During a review after Mr Hooper's death, the Primary Care Clinical Lead noted that the sample pot had not been collected and agreed that a process would be implemented to prevent this happening again.)

Events of 20 May 2022

34. At about 11.00am on 20 May, an HCA went to Mr Hooper's cell to carry out a welfare check. She saw that Mr Hooper had been sick, that he appeared confused and looked pale. Mr Hooper told her that he had been drinking fluids but had stomach pain. She asked an officer to find a nurse.

35. A nurse went to Mr Hooper's cell. He noted that Mr Hooper had a high pulse rate, a high respiratory rate, a low temperature and a National Early Warning Score of 5 which indicated a medium clinical risk. He asked for the emergency nurse to see Mr Hooper and arrange for him to go to hospital.

36. A nurse saw Mr Hooper in his cell. He saw dried blood on his bed and considered that Mr Hooper was dehydrated. He was unable to obtain a radial pulse or a blood oxygen saturation reading.

37. At 11.36am, an officer and a nurse explained Mr Hooper's condition to the ambulance service.

38. At 12.05pm, an ambulance arrived at Channings Wood and at 12.10pm, paramedics were at Mr Hooper's side. At 12.15pm, Mr Hooper went into cardiac arrest. An officer radioed a medical emergency code blue and a number of other healthcare staff attended.

39. Ambulance paramedics and healthcare staff tried to resuscitate Mr Hooper, including giving chest compressions and inserting an airway to give him oxygen.

40. At 12.40pm, ambulance paramedics detected a heartbeat and at 1.17pm, took him to hospital, unrestrained.

41. At 3.38pm that day, Mr Hooper died in hospital.

Contact with Mr Hooper's family

42. On 20 May, a prison manager appointed a family liaison officer (FLO). At 2.58pm, the FLO telephoned Mr Hooper's friend and told her that he was seriously unwell and had been taken to hospital. At 3.38pm, the FLO telephoned Mr Hooper's friend again told her that he had died and offered her condolences. He remained in contact with Mr Hooper's friend. Mr Hooper's funeral took place on 8 July. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

43. After Mr Hooper's death, the Head of Safety and Equalities debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Hooper's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Hooper's death.

Post-mortem report

45. A post-mortem examination established that Mr Hooper died from a perforation a benign gastroduodenal ulcer.

Inquest

46. At an inquest held on 16 January 2025, the Coroner concluded that Mr Hooper died of natural causes.

Findings

47. The clinical reviewer concluded that the clinical care that Mr Hooper received at Channings Wood was good and was equivalent to that which he could have expected to receive in the community.

48. The clinical reviewer found that the emergency response and care provided to Mr Hooper on 20 May was of a high clinical quality. Good quality life support was given which resulted in a return of a heart rhythm.

Good Practice

49. The clinical reviewer found many examples of good clinical practice in Mr Hooper's case. She said that Mr Hooper's needs were responded to proactively and the care provided was personalised and in line with National Institute for Health and Care Excellence (NICE) guidelines.

50. The clinical reviewer found that the healthcare record-keeping on the day that Mr Hooper died should be commended as an example of good contemporaneous record-keeping.

51. The clinical reviewer made one recommendation which is not directly related to Mr Hooper's death but which the Head of Healthcare will need to address.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T l 020 7633 4100