Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Campbell, a prisoner at HMP Channings Wood, on 19 May 2023

A report by the Prisons and Probation Ombudsman

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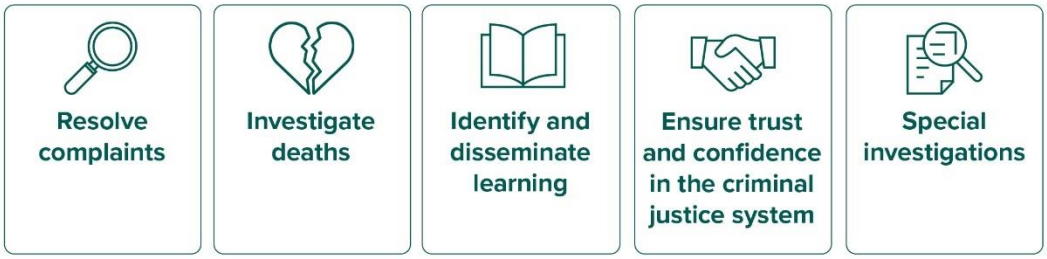
OUR VISION

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

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 Richard Campbell died on 19 May 2023 of idiopathic dilated cardiomyopathy (heart muscle disease) while a prisoner at HMP Channings Wood. He was 49 years old. We offer our condolences to Mr Campbell's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Campbell received at Channings Wood was equivalent to what he could have expected to receive in the community. He did, however, find that healthcare staff had prioritised another prisoner to attend an outpatient clinic over Mr Campbell and he concluded that this aspect of Mr Campbell's care was not equivalent. The clinical reviewer made a number of recommendations about matters that were not directly related to Mr Campbell's death that the Head of Healthcare will want to address.

The Investigation Process

5. HMPPS notified us of Mr Campbell's death on 19 May 2023.

6. NHS England commissioned an independent clinical reviewer to review Mr Campbell's clinical care at Channings Wood.

7. The PPO investigator investigated the non-clinical issues relating to Mr Campbell's care.

8. The PPO family liaison officer wrote to Mr Campbell's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some typing errors in the clinical review, and the clinical review has been amended accordingly.

Previous deaths at HMP Channings Wood

10. Mr Campbell was the seventh prisoner to die at Channings Wood since May 2021. Of the previous deaths, four were from natural causes, one was drug related and one was self-inflicted. Since Mr Campbell's death, there have been three deaths, which are still under investigation.

11. In our previous investigation into the death of a prisoner at Channings Wood in August 2021, we recommended that the prison ensure documents were securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service policy. The prison assured us that revised measures were introduced to ensure that evidence for the use of restraints would be available.

Key Events

12. On 25 August 2022, Mr Richard Campbell was sentenced to three years and four months in prison for sexual offences and was sent to HMP Bristol. He was 49 years old. On 28 October, Mr Campbell was transferred to HMP Channings Wood.

13. Mr Campbell had several long term conditions. He was born with one kidney, and by 2006, he had chronic kidney disease. He also had Crohn's disease, high blood pressure and bile acid malabsorption (where excess bile acids trigger the colon to secrete extra water, leading to watery stools). Healthcare staff saw him regularly and adjusted his medications to manage his conditions. They made appointments for him to see hospital gastroenterology and nephrology (kidney disease) specialists.

14. From 5 January 2023, Mr Campbell had a prolonged flare up of his Crohn's disease. He had bloating, abdominal pain and shortness of breath. Healthcare staff arranged for him to be transferred to hospital on 18 February. In addition to trying to stabilise his long term conditions, hospital specialists diagnosed Mr Campbell with dilated cardiomyopathy (heart disease), heart failure, low sodium, high potassium and peripheral oedema (swelling to the lower limbs).

15. Mr Campbell was restrained for the duration of his hospital admission. His medical record noted that he had pressure sores on his left wrist from the handcuffs.

16. On 13 March, Mr Campbell was discharged from hospital back to Channings Wood. Ten days later, healthcare staff arranged for his return to hospital because a GP at the prison considered that Mr Campbell was extremely ill and appeared not fit for a prison environment; he had low sodium levels, high potassium levels, high risk of sepsis, acute heart and kidney failure. A paramedic at the prison contacted the hospital registrar who, after receiving Mr Campbell's abnormal blood test results, agreed that Mr Campbell should be in hospital. Mr Campbell remained in hospital for one day and hospital specialists said that his condition was unchanged from his last hospital admission and despite his abnormal blood tests, he should return to Channings Wood.

17. Mr Campbell returned to Channings Wood on 23 March. The reception nurse noted that he was scoring 5 on his NEWS (National Early Warning Score) and was tired, lethargic and healthcare staff had to take his medication to him in his cell because he was too unwell to move.

18. On 27 March, a GP at the prison completed a review and discussed resuscitation wishes with Mr Campbell. Mr Campbell said that he wanted to be resuscitated in the event of cardiac or respiratory arrest.

19. On 16 April, Mr Campbell reported to staff that he had passed out. The paramedic at the prison noted that Mr Campbell was slower in movement and cognition. The paramedic contacted the hospital medical registrar and agreed that Mr Campbell should be admitted to hospital. The prison could not find did the escort risk assessment for this hospital admission, so we do not know whether restraints were used.

20. In hospital, specialists noted that Mr Campbell was nearing the end of his life and placed him on palliative care. Mr Campbell agreed to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which meant that he would not be resuscitated if his heart or breathing stopped.

21. On 18 April, Mr Campbell said that he did not want to stay in hospital and wanted to return to Channings Wood. He returned to prison later that day and prison staff created a care and support plan which included arrangements for healthcare staff to monitor him during the day and agency staff to monitor him during the night.

22. The next day, hospital staff completed a hospice referral. The hospice team completed a review on 21 April and suggested medication changes. They considered that a hospice transfer was not needed immediately but might be appropriate at a later date.

23. Release on compassionate grounds is 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. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family.

24. On 21 April, prison staff started a request for compassionate release. The hospital consultant noted that despite his deteriorating condition, Mr Campbell would still be able to commit offences linked to his sentence and at that stage he did not have a terminal prognosis. Prison escorting staff noted that in hospital he had been manipulative and had also made inappropriate comments about nurses. Mr Campbell later said that he did not wish to pursue the application and wanted to die in prison. On 24 April, the application was refused.

25. Mr Campbell's condition deteriorated, and, on 9 May, he was transferred to a hospice. Two officers accompanied Mr Campbell and he was not restrained.

26. On 19 May, it was confirmed that Mr Campbell had died in the hospice.

Cause of death

27. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Campbell's cause of death as idiopathic dilated cardiomyopathy (heart disease). Chronic kidney disease was also listed as a contributory factor.

Non-Clinical Findings

Retention of evidence

28. We asked Channings Wood to provide us with the escort risk assessments for Mr Campbell's transfer and admission to hospital between February and April 2023. When the Investigator requested documentation regarding the use of restraints, staff in safer custody, security and the offender management unit (OMU) confirmed that they could not locate the documents. The safer custody manager said that he would raise the issue of missing documentation at the weekly senior management meeting.

29. We know that Mr Campbell was restrained for a prolonged period during an earlier hospital admission between February and March. However, we were not able to assess whether the restraints used during the later escorts were appropriate given Mr Campbell's physical health, but also considering his risks and previous behaviour.

30. In a previous investigation into the death of a prisoner at Channings Wood in 2021, we did not receive all the hospital escort documents. We recommended that the prison ensured documents were securely stored and promptly provided to us following a death in custody, in line with Prison Service Instruction 58/2010. The head of security and head of safety and equality accepted our recommendation and said that their contingency plans for deaths in custody would be amended by 31July 2022, so that a nominated person would ensure relevant evidence was secured, logged, retained and monitored via the monthly safer custody meeting. Initially, the prison could not locate the relevant documents for this investigation. However, several weeks later they did locate the paperwork. We have therefore removed the recommendation about securing evidence.

Good practice

31. Prison Service Instruction (PSI) 64/2011, about safer custody, 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. There was particularly good family liaison before and after Mr Campbell died.

32. When Mr Campbell's health deteriorated prison staff ensured arrangements began for his cell door to remain unlocked so prison and healthcare staff could complete frequent checks on him.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

Inquest

The inquest, held on 19 March 2025, concluded that Mr Campbell died from natural causes.

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