

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Suckley, a prisoner at HMP Channings Wood, on 15 July 2025

A report by the Prisons and Probation Ombudsman

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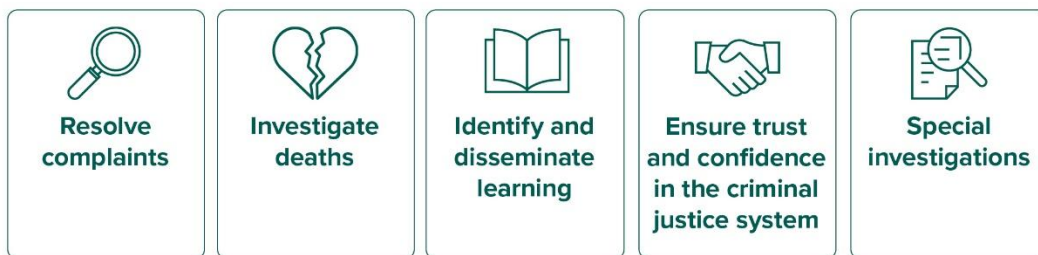
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OUR VISION

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



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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. In May 2023, Mr Gordon Suckley was sentenced to 15 years and three months imprisonment for sexual offences. He died of aspiration pneumonia (infection of the lungs) caused by pseudo bowel obstruction (when the intestines have symptoms of a blockage but there is not a physical blockage) which, in turn, was caused by hiatus hernia (when part of the stomach moves up in the chest). Frailty of old age and chronic kidney disease also contributed to but did not cause his death. He was 89 years old when he died on 15 July 2025, in hospital. We offer our condolences to Mr Suckley's family and friends.
4. The Ombudsman's office wrote to Mr Suckley's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer, to review Mr Suckley's clinical care at Channings Wood. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Suckley received at Channings Wood was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, he found that a quantitative faecal immunochemical test (qFIT - used to detect blood in faeces) was requested but never followed up. We make the following recommendation:

The Head of Healthcare should ensure that there is a robust safety net procedure in place to ensure that qFITs take place as requested.
7. The clinical reviewer also made recommendations not related to Mr Suckley's death that the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Suckley's care.
9. We did not find any non-clinical issues of sufficiently serious concern to make a recommendation but bring the below to the Governor's attention in relation to the liaison with Mr Suckley's family following his death.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Governor to note

11. The prison contacted Mr Suckley's family before his death and told them when he died in a timely manner. However, after this, there was a miscommunication about who was the allocated family liaison officer (they had just completed their training) and, consequently, no one contacted his family again until early August to offer follow up support. We bring this to the Governor's attention to ensure new family liaison officers are appropriately supported.

Adrian Usher
Prisons and Probation Ombudsman

January 2026

Inquest

12. The inquest into Mr Suckley's death finished on 29 June 2026 and concluded that Mr Suckley died of natural causes.



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