Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Godsave, a prisoner at HMP Channings Wood, on 31 July 2023

A report by the Prisons and Probation Ombudsman

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

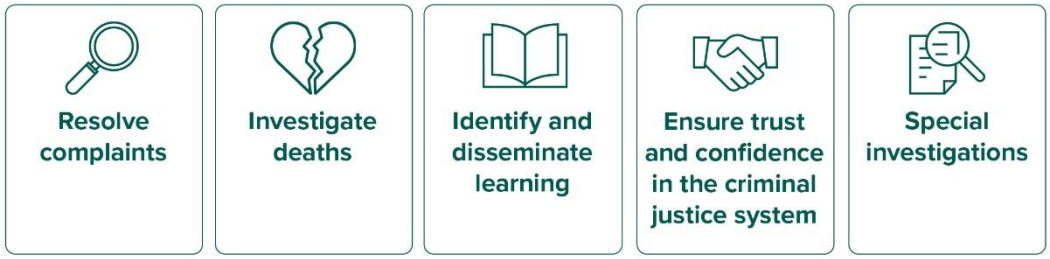
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 David Godsave died of metastatic lung cancer (cancer which had spread) on 31 July 2023 at HMP Channings Wood. He was 78 years old. We offer our condolences to Mr Godsave's family and friends.

4. The PPO family liaison officer wrote to Mr Godsave's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Godsave's clinical care at HMP Channings Wood. They concluded that the clinical care Mr Godsave received at HMP Channings Wood was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. The clinical review is attached as Annex 1.

6. The PPO investigator investigated the non-clinical issues relating to Mr Godsave's care. We did not find any non-clinical issues of concern. We make no recommendations.

7. The clinical reviewer made four recommendations which were not related to Mr Godsave's death but which the Head of Healthcare will want to address.

8. We shared our initial report with HMPPS and the prison's healthcare provider. They found no factual inaccuracies.

9. We sent a copy of our initial report to Mr Godsave's next of kin. They pointed out two factual inaccuracies in the clinical review, which have been corrected.

10. At the inquest, held on 28 May 2025, the Coroner concluded that Mr Godsave died from natural causes.

Adrian Usher **December 2025**
Prisons and Probation Ombudsman

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 I 020 7633 4100