

**Investigation into the circumstances surrounding  
the death of a man at hospital,  
while a prisoner at HMP Channings Wood,  
in January 2012**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2012**

This is the report of an investigation into the death of a man, who died in hospital in January 2012. He was a prisoner at HMP Channings Wood and was 71 years old when he died. A post mortem examination concluded that the cause of death was heart failure caused by coronary artery disease. Pneumonia was also listed as a contributing factor. I offer my condolences to his family and friends.

This investigation was carried out by an Assistant Ombudsman. A review of the man's clinical care while he was at Channings Wood was commissioned by the local PCT and conducted by a clinical reviewer.

The man was sentenced in July 2011 and originally held at HMP Bristol. He had problems with asthma and mobility, both of which were treated appropriately. In September, he was transferred to Channings Wood. The clinical reviewer has found that he was cared for satisfactorily while at the prison. On 8 January 2012, he collapsed and was taken to hospital. At hospital, he underwent a range of tests and treatment, but, before his underlying health problem could be determined, his health deteriorated significantly and he died.

The man received appropriate care while he was in prison and nothing could have been done to prevent his death. However, I am concerned that for most of the time he was in hospital, restraints were used which did not seem to be justified by the risk assessment completed by the prison. Arising from the investigation, the clinical reviewer made a suggestion, which I endorse, that as a matter of good practice, smokers at the prison over 50 should be offered a cholesterol test.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2012**

## **CONTENTS**

Summary

The investigation process

HMP Channings Wood

Key events

Issues

Conclusion

Recommendations

## SUMMARY

1. The man was 71 years old when he died at hospital in January 2012. He died of heart failure caused by coronary artery disease. Pneumonia was also a contributing factor.
2. He had been convicted of serious offences at Crown Court on 29 June 2011. On 29 July, he was given a seven year prison sentence and was taken to HMP Bristol.
3. When he arrived, he underwent a health screen. The nurse noted that he had asthma, for which he was receiving medication. His mobility was reduced (he used a walking stick). He also had impaired eyesight and hearing. He was assessed by the community nurse for older people.
4. On 3 August, the man saw another nurse who recorded his weight as 52.45kg. He was referred to a smoking cessation clinic. Staff at Bristol confirmed with his community GP that he was receiving vitamin B12 injections, as he had low levels of the vitamin following stomach surgery. They arranged for the injections to continue.
5. The man transferred to HMP Channings Wood on 15 September. He underwent another health screen, and his weight was recorded as 55kg. (His ideal weight was noted as being 74.5kg. However, his Body Mass Index (BMI, a measure of weight to height ratio) was noted as 18.38kg/m<sup>2</sup>, just below the normal limit of 18.5kg/m<sup>2</sup>).
6. In October, the man was seen at the initial bowel cancer screening clinic and a referral was sent to the local screening hub. He was seen by a nurse at an asthma clinic in November, when his weight was recorded as 50.8kg. He was advised to take ventolin (used to treat or prevent breathing problems in patients who have asthma) before any long walks. He said that he did not want to give up smoking.
7. On 8 January 2012, the man collapsed in the breakfast queue at the prison. Healthcare staff attended quickly. They conducted an electrocardiogram (ECG) test, which measures electrical activity in the heart. This suggested that there was some damage to his heart. His blood sugars were low, and it was noted that he had lost one and a half stones in the previous four months. An out-of-hours doctor was called, and it was decided to send him to hospital for further tests.
8. The man was taken to hospital. On 10 January, he underwent an operation after a scan suggested lung abnormalities. Although treatment was continued, doctors were not sure of the root cause of his illness. He continued to deteriorate, and died with members of his family present.

## THE INVESTIGATION PROCESS

9. This office was notified of the man's death on 20 January. An Assistant Ombudsman led the investigation. Notices were sent to Channings Wood inviting staff and prisoners to contact him if they wished to contribute to the investigation. We received no replies in response.
10. The Assistant Ombudsman went to Channings Wood to open the investigation formally on 25 January. While at the prison, he spoke to the Duty Governor, the officer who was present when the man collapsed on 8 January, another officer who was part of the bedwatch team and also acted as the prison's family liaison officer, and the Acting Head of Healthcare. These conversations were not recorded. He also spoke to a member of the Independent Monitoring Board, the prison chaplain and a representative from the Prison Officers' Association. Many of these conversations were arranged at short notice and we are grateful to all concerned for their contributions to the investigation.
11. A review of the healthcare the man received while he was in prison was commissioned by the local PCT. A clinical reviewer was appointed to lead the review. We are grateful for his timely report.
12. One of the Ombudsman's Family Liaison Officers contacted the man's family to inform them of the purpose of the investigation and offer them the opportunity to contribute. The family commented that his weight appeared to decline after arriving at Channings Wood. They were concerned that this should have been picked up by healthcare staff and asked whether this could have been a contributing factor in his death. They were also concerned that a walking stick, which had been given to him by his daughter, had not been returned with his property. Both of these matters are discussed in the 'Issues' section of this report. The family also mentioned that there had been some confusion about the payment of funeral expenses. This matter was discussed with the prison and satisfactorily resolved.
13. The Assistant Ombudsman also contacted the Coroner for Torbay and South Devon in order to obtain the results of the post mortem examination. A copy of this report will be sent to the Coroner to assist with his enquiries.

## **HMP CHANNINGS WOOD**

14. HMP Channings Wood is a category C prison in Devon. (All prisoners are allocated a security category based on factors including their offence, risk of escape and risk to the public if they did escape. Category C prisoners are those who, typically, could not be trusted in open conditions, but who are thought unlikely to escape). The prison holds a maximum of 731 prisoners.
15. The man lived on Fleet Wing, part of a unit which also has another wing called Weaver. Fleet Wing contains 28 single cells and three double cells, and shares facilities such as the dining room and treatment room with Weaver Wing.
16. Healthcare services are provided by the Devon Partnership Trust. There is nursing cover during the day between 5.00am and 7.45pm from Monday to Thursday, and until 5.00pm on Friday and at weekends. The GP service is provided by a company called Devon Doctors.

## **HM Chief Inspector of Prisons' report**

17. The last inspection of Channings Wood took place in July 2010. It was an unannounced short follow-up inspection to a previous full inspection in 2007. A report was issued in September 2010. The then Deputy Chief Inspector of Prisons, in his foreword, said that Channings Wood continued to be a "reasonable training prison, providing a generally safe and purposeful environment".
18. Inspectors commented positively on a clinic for older prisoners, with all men over 55 offered an assessment and a policy for older prisoners based on the National Service Framework for older people. They found that healthcare was "better integrated into the work of the prison" than it had been in 2007, and that, overall, services were reasonably good.

## **Independent Monitoring Board report**

19. Each prison is monitored by an Independent Monitoring Board (IMB), made up from members of the local community. The IMB is charged with satisfying itself of the humane and just treatment of those held in the prison, and has unfettered access to the prison. They have a duty to inform the Secretary of State for Justice of any concerns and to report annually on how well the prison has met the standards required of it.
20. The most recent report published by the Channings Wood IMB covers the period from 1 September 2010 to 31 August 2011. Overall, the report is very positive about the prison but the IMB expressed concern about the healthcare contract. In particular, they noted the extensive use of locum doctors, which they believed did not give prisoners continuity of care. The IMB were also concerned about the number of referrals to hospital and the shortage of prison officers that resulted from the increased use of escorts.

21. The Assistant Ombudsman discussed this issue on 25 January with a member of the IMB. The IMB member said that the IMB had no direct experience of the use of locum doctors, but they had been concerned to hear that staff had been told by Devon Doctors to call an ambulance out of hours. He stressed to the Assistant Ombudsman that the regular healthcare staff and discipline staff were of high quality.

## **KEY EVENTS**

22. The man was convicted of serious offences at Crown Court on 29 June 2011. On 29 July, he was sentenced to seven years imprisonment, and was taken to HMP Bristol.
23. On arrival at Bristol, the man was seen by a nurse for a reception health screen. He explained that he had asthma and had been prescribed a seretide inhaler, tiotropium bromide and ventolin (medications used to help manage this condition), as well as chewable calcium tablets. He also had mobility problems (for which he used a stick), as well as impaired eyesight and hearing. He said that he had taken an overdose in October 2010, but had no further thoughts of harming himself. A further supply of his medication was issued on 31 July.
24. On 2 August, the man saw a locum GP. He told her that he used to have vitamin B12 injections (a later entry in his medical record, from 22 August, suggests that these started in 2004 and were possibly related to stomach surgery in 1973). The doctor asked healthcare staff to contact his community GP to confirm this. (Following confirmation from his local doctor injections were started on 22 August.)
25. A second health screen was conducted on 3 August, by a Healthcare Assistant (HCA). The man's weight was noted as being 52.45kg. He was referred to the smoking cessation advisor. He told the HCA that his mobility had been reduced after he previously fractured his thigh bone.
26. On 5 August, the man saw the smoking cessation advisor. He was given nicotine patches, but developed an allergy to the patches and was, instead, given nicotine lozenges. On 8 August, healthcare staff assessed him as fit to play skittles, but told him not to take part in any cardiovascular exercise or weight lifting.

## **HMP Channings Wood**

27. The man moved to Channings Wood on 15 September. It was noted in the Person Escort Record (PER) that he had asthma, problems with his hearing and sight and reduced mobility. These issues were noted during a health screen conducted by a nurse. She also recorded his weight as 55kg, against an ideal weight of 74.52kg for a man of his height. (However, his Body Mass Index was recorded as 18.38kg/m<sup>2</sup>. This is just below the normal range, which starts at 18.50kg/m<sup>2</sup>.) He moved into a single cell on Fleet Wing.
28. On 7 October, the man saw a nurse, who told him about the bowel cancer screening programme. The nurse advised that a referral had been made for him.
29. He next saw healthcare staff on 3 November, at an asthma clinic run by a nurse. He told her that he did not want to give up smoking. He was advised

to take ventolin before walking long distances. She recorded his weight as 50.08kg.

## 2012

30. On 8 January, the man collapsed while waiting in the queue in the dining room to collect his breakfast. (The dining room is between Fleet and Weaver wings.) An officer was informed of his collapse by other prisoners and asked the emergency healthcare response nurse to come to the dining room. A nurse arrived shortly afterwards. In her note in his medical record (which was made at 9.54am), she wrote that “he was apparently unconscious for about 1 minute (witnessed by prisoners, no staff). On arrival he was sat on a chair looking very pale and a little shaky”.
31. She took him to the nearby treatment room. She recorded his blood pressure as within normal range, but also conducted an electrocardiogram (ECG) which suggested that there was a “non-specific intraventricular conduction block” (a problem with the electrical activity in the heart). His blood sugar level was also low, so she gave him some toast and glucogel (a gel containing a high amount of dextrose, a quickly absorbed sugar). She also noted that he had lost one and a half stones in the previous four months. She decided to call an out of hours doctor, and continued to check on him regularly until the doctor arrived.
32. At approximately 11.00am, the man was seen by a doctor from Devon Doctors (the note in his clinical record was made at 11.16am). The doctor noted that his blood pressure was now low and his pulse irregular. He thought he might have hypoglycaemia (low blood sugar) and a possible “underlying malignancy”. He referred him to hospital. After he was taken to hospital the same day, the escort officers were told that he was expected to stay in hospital for “two or three days”.
33. At 8.40am the next day, a consultant at the hospital saw the man. According to one of the escort officers, the consultant was “worried about lung abnormalities” and arranged for a scan later that morning. That afternoon, the consultant told him that he needed an operation, which was scheduled for 10 January.
34. The next day, 10 January, another escort officer spoke to the Duty Governor, who confirmed that the escort chain (a length of chain attached to an officer and the prisoner by a handcuff at either end) be removed during the operation. The Governor also asked the officer to contact the man’s daughter and advise her to contact the nursing staff at the hospital. Following the operation, he was taken to the recovery room. The escort chain was put back on at 8.30pm.
35. At 9.30am on 11 January, it was noted that the escort chain had been removed again as the man was on an epidural drip (a tube inserted in the back) to help with his pain. The chain was reapplied when the drip was removed at 12.05pm. Later that afternoon, he was seen by the pain team,

and also by a doctor when his breathing became difficult. At 8.30pm, he underwent a chest X-ray.

36. The next morning, one of the escort officers recorded that the man had been “very unsettled” throughout the night, and that observations had been done every half an hour. At 9.40am, a doctor told him that he needed to increase his intake of calories. Later that day, he was put on a drip as he was dehydrated.
37. The man spoke to his wife on the telephone at 12.00pm on 13 January. That afternoon, a doctor planned to undertake an endoscopy (a procedure in which a tiny camera is inserted into the body to help medical staff understand the patient’s illness). However, he thought that it was too soon after the operation to conduct the test.
38. The next day, the consultant visited the man at 12.00pm. He told the officer that he “was not sure of the root problem” and that he would need further tests once his chest infection had cleared. That afternoon, he underwent another chest X- ray and a blood test. The man told the officer that he was frustrated that the hospital could not find the underlying cause of his illness. At 6.30pm, he was moved to the Intensive Care Unit (ICU) to allow a machine to help his breathing.
39. Over the next two days, the man remained on the ICU. A nurse recorded in his prison medical record on 16 January that he had been taken off antibiotics as staff did not think that he had an infection. A Duty Governor authorised the removal of the escort chain that morning, for the duration of his stay on the ICU. He also received a visit from family members that morning.
40. On 17 January, the man was visited by his wife and daughter. Later that day, the Governor of Channings Wood and the Chaplain also visited. He was seen by a dietician later that day.
41. The next day, he was visited by the hospital chaplain, who gave him a cross. Later that evening, at 7.40pm, he was moved to Simpson Ward and the escort chain was reapplied. The escort officers recorded in the bedwatch log that he was polite and courteous to staff and that there were no security issues. He spent the evening using a nebuliser to help him breath.
42. On 19 January, doctors told the man that they expected him to be at the hospital for at least four weeks, and then at a smaller hospital for a further three to five weeks. That day, he declined all food “as he was struggling to digest it”. Hospital staff offered him food that was not on the usual menu to try and encourage him to eat. An officer spoke to the man’s granddaughter at 7.30pm and told her what he could about his condition. He let her speak to a nurse for more information. Later in the evening, the man was moved onto an airbed as he was uncomfortable.

## 20 January

43. At midnight on 20 January, an officer recorded that the man was having problems breathing, and that a nurse had taken an ECG, which she said was “normal”. However, she called a doctor because of his difficulty with breathing. The doctor performed some blood tests.
44. He was next seen by a doctor at 8.20am, who said that he might conduct an echocardiogram test to check his heart. Later that morning, nurses replaced his feeding tube. At 1.30pm, two other officers relieved colleagues and took over the prison escort. He underwent another chest X-ray at 2.00pm, this time using a portable machine. Shortly afterwards, his daughter-in-law spoke to Officer A and said that she would be visiting the next day.
45. At 2.50pm, hospital staff became more concerned about the man. Officer B removed the escort chain because of his deteriorating condition. He informed the Duty Governor and they discussed contacting the next of kin. At the same time, the doctor at the hospital also tried to contact his wife to update her.
46. The Duty Governor visited the hospital at 6.15pm. Shortly afterwards, the man’s son and daughter-in-law arrived, followed at 7.00pm by his daughter and granddaughter. Officer A, who is a trained family liaison officer (FLO), spoke to them before they went to see him. They were with him when he died at 8.50pm.
47. Before leaving the hospital, Officer A explained to the man’s family about the procedures following his death, including the post mortem and funeral. She agreed to arrange to collect his property and return it to them in Bristol.
48. Notices to staff and prisoners were issued informing them of the man’s death. The next day, all prisoners subject to self harm monitoring were reviewed. The two officers were both offered the support of the prison’s care team.
49. Over the next few days, Officer A spoke to the man’s daughter-in-law several times, offering the prison’s help with the cost of his funeral and a visit to Channings Wood. Because of delays in completing a post mortem, the funeral had to be postponed. When speaking to the Ombudsman’s family liaison officer, the family spoke positively about the help and support they had received from the officer.
50. The post mortem examination was completed on 26 January. The cause of death was recorded as left ventricular failure (failure of the heart muscle) secondary to coronary artery disease. Pneumonia was also listed as a contributing factor.
51. The funeral took place on 8 February. At the request of the family, no members of prison staff attended the funeral. However, in accordance with the wishes of the family, Officer A delivered the man’s property to them shortly after they returned from the funeral.

## ISSUES

### Clinical care

52. In his clinical review, the clinical reviewer summarises his findings as follows:

“I believe that this was a death from natural causes. I do not believe that there was any deficiency in his health care which would have contributed to his death.”

53. The clinical reviewer was asked by the investigator to comment specifically on the man’s weight. The clinical reviewer noted that he was underweight when he was admitted to prison in July 2011. However, he also found that the man’s weight was monitored while he was in custody, and was recorded as decreasing. He explained that the man was a smoker with respiratory disease, and this was the likely cause of his low weight. He was advised to stop smoking, and was offered help to achieve this, but declined to do so. He also found that there was no indication of heart disease before he collapsed.

54. The clinical reviewer commented that, in addition to the smoking cessation advice, the man was given access to bowel cancer screening and was advised how he could use his asthma inhaler better. However, he considered that, although “the records relating to his health promotion would be considered to be adequate”, staff at Channings Wood should also have considered testing his cholesterol level. He believes that offering this test to prisoners who are over 50 years old and who smoke would help reduce the number of deaths in prison from vascular or circulatory disease. We make the following recommendation:

**The Head of Healthcare should introduce cholesterol tests for prisoners over 50 who smoke.**

### Response of locum doctors

55. The IMB highlighted concerns in its latest report about the use of locum doctors and the perceived increase in referrals to hospital as a result. In this case, the referral to hospital was timely and appropriate. An out of hours doctor employed by Devon Doctors attended the prison and fully assessed the man before deciding to refer him to hospital.

### Use of restraints

56. When the man was first taken to hospital on 8 January, he was restrained using an escort chain. The chain was removed, firstly, while he underwent an operation on 10 January, and again on 11 January for another medical procedure. After he was moved to the ICU, restraints were again removed on the understanding that they would be reapplied should he move back to a normal ward which they were. The escort chain was finally removed on 20 January when his condition deteriorated further, just a few hours before he died.

57. When the man was initially taken to hospital on 8 January, a risk assessment was completed. As part of this the healthcare assessment questions were ringed to indicate there was no medical objection to the use of restraints, that the hospital management had not been consulted and the next of kin had not been informed. It is not clear who completed this part of the form and it is not signed or dated. No other part of the health care assessment was completed and there is no evidence of any further medical assessment during his stay in the hospital.

58. At the time that the man was first taken to hospital he was escorted by two officers and was restrained by the use of an escort chain. It is possible that at the time this was a reasonable decision except that the security part of the risk assessment, completed by the security manager, indicated that his risk to the public, risk of hostage taking, escape potential and likelihood of outside assistance were all low. There is no explanation why, with this assessment, it was decided that two officers and the use of restraints were needed, or that any alternative bed watch arrangement was considered. While the prison kept the arrangements under review, and removed restraints when he was undergoing treatment and when he was in the intensive care unit, it was not until shortly before his death that the restraints were permanently removed. In the circumstances, this appears a risk averse approach rather than a considered decision based on the facts. We make the following recommendation:

**The Governor should ensure that escort arrangements are proportionate to risk and that all relevant sections of the risk assessment are completed each day a prisoner is in hospital, so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.**

### **The man's property**

59. The man's family asked the investigator to establish whether a walking stick he had used was still at Channings Wood. The stick was not with his property when his family visited him in hospital. The investigator contacted the prison's liaison officer, who conducted two searches at his request. She has also confirmed that the stick was not recorded on his property card, and was not in his cell when it was cleared after his death. The stick has still not been found and it is not possible to know whether he took it with him when he first went to hospital on 12 January and it was lost there, or was mislaid in the prison. Unfortunately, we are therefore unable to resolve this matter.

## **CONCLUSION**

60. The man already had health problems when he arrived in prison in 2011. He had asthma and mobility issues. The clinical reviewer has assessed that his clinical care was adequate, although he has also recommended that the prison offer cholesterol testing.
61. When the man collapsed on 8 January, he was quickly assessed by medical staff, before being sent to hospital. While there, he was guarded by two officers and also restrained using an escort chain, although his security risk on the escort risk assessment documentation was assessed as low. The escort chain was removed intermittently while he was undergoing treatment and then finally in the hours before his death on 20 January.
62. The man's walking stick, a present from his daughter, was not returned with his property. Although staff from the prison tried to locate it, they have not been successful and it is not possible to know when or where it was lost.

## RECOMMENDATIONS

1. The Head of Healthcare should introduce cholesterol tests for prisoners over 50 who smoke.

NOMS accepted this recommendation and commented: "Healthcare now provide screening on Reception for prisoners over 50 who smoke."

2. The Governor should ensure that escort arrangements are proportionate to risk and that all relevant sections of the risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

NOMS accepted this recommendation and commented: "A Risk Assessment review sheet has been added to the bedwatch pack, this will be completed by the visiting Manager in the event of any change either to the patient's health, physical ability, and location or as a reaction to information/intelligence. Operational Managers have been briefed by the Deputy Governor on the need to risk assess the use of restraints as the prisoner's health changes. The recent email from NOMS on the concordat between NOMS and NHS was circulated to Operational Managers on 28/3/12. A copy is also in the SMT folder on P drive. Therefore, every effort has been made to inform Operational Managers on their decision making."