



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in
February 2013 while in the custody of HMP Channings
Wood**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, a prisoner at HMP Channings Wood. He died at hospital in February 2013, where he had been admitted five days earlier. He was 50 years old. The cause of his death was blood poisoning and heart and liver disease. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the clinical care the man was given. The prison cooperated fully with the investigation,

The man had a history of poor health, associated with alcoholism. Despite the advice of healthcare staff at the prison, he was reluctant to undergo tests and was often uncooperative about receiving treatment. He became very unwell on 14 February and had to be persuaded to be admitted to hospital, where it was found that he had a rare infection of his heart valves. Despite prompt and intensive medical intervention, he did not respond to treatment. A doctor told him his condition was terminal but his health deteriorated far more quickly than was predicted. Although his death came suddenly, it was known that he was dying yet he remained chained to an officer.

The clinical review is satisfied that the man received an appropriate standard of care at the prison. However, I am most concerned that, as has happened previously at Channings Wood, a prisoner remained unnecessarily chained to an officer almost to the point of death. I cannot regard this as decent or humane. The Governor needs to review the risk assessment process for prisoners with terminal conditions in hospital so that this does not happen again.

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

November 2013

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SUMMARY

1. On 12 June 2012, the man was released on licence from a prison sentence. He breached the terms of his licence and was recalled to prison on 22 October 2012. Initially he was held at Exeter prison. He transferred to Channings Wood in November.
2. The man had a history of poor health which was attributed to his alcoholism. He had cirrhosis of the liver and hepatitis. He also said that he had post traumatic stress disorder after serving as a soldier in the Falklands war.
3. On 25 October, while at Exeter prison, the man suffered a stomach bleed and was admitted to hospital. On 30 October, while an inpatient at the hospital, he was found by a prison officer drinking the hand gel in the patient's toilet. He returned to the prison the same day with appropriate medication. During his time at Exeter, he fell from his bunk bed and reported injuring his back and ribs for which he was given painkillers. He said the bed had a faulty hand rail.
4. On 14 February 2013, the man said he felt unwell. He was examined by a nurse who was concerned about him. The nurse arranged a doctor's appointment for him later that day but he refused to attend.
5. That evening the man felt very unwell. A nurse examined him and called an out of hours doctor to the prison. The doctor diagnosed pneumonia and heart problems and persuaded him to go to hospital. He was taken in an emergency ambulance to hospital and admitted as an inpatient.
6. The man's condition deteriorated in hospital and he had surgery to fit a pacemaker on 18 February. However, he continued to deteriorate. A hospital doctor told him that his condition was terminal, and his organs were shutting down, although his death was not expected to be imminent. He appeared to take the news calmly, and was able to speak to his mother, who lives in Spain.
7. The man died unexpectedly quickly, later that day. Because of the prognosis a senior officer escorting him had asked the prison for permission to remove his restraints earlier in the day. He was told that the duty governor would visit the prison to assess the situation later. At 4.50pm, he appeared to be unresponsive. Hospital staff were called and the senior prison officer removed his restraints. Within five minutes, it was confirmed that he had died.
8. The clinical review considers that the man received a good and prompt level of care in relation to his healthcare. We are very concerned, as we have been in previous cases at Channings Wood, about the inappropriate use of restraints, almost to the point of death. We again make a recommendation about risk assessments for the use of restraints.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 20 February. The investigator issued notices about the investigation to staff and prisoners at Channings Wood asking anyone with relevant information to contact her. She spoke to one prisoner who wrote to her in response.
10. The investigator visited HMP Channings Wood on 27 March. A clinical review of the man's healthcare in prison was carried out by a clinical reviewer on behalf of the local PCT. The investigator and clinical reviewer interviewed five staff members and one prisoner. The investigator fed back preliminary findings to the Governor during the investigation.
11. HM Coroner was informed of the investigation and provided the preliminary cause of death. A copy of our investigation report has been sent to the Coroner.
12. One of the Ombudsman's family liaison officers wrote to the man's mother shortly after his death and explained the purpose and scope of the investigation. She did not identify any specific issues for the investigation to consider. The family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP CHANNINGS WOOD

13. HMP Channings Wood is a category C prison near Newton Abbott, in Devon. It holds over 700 convicted adult prisoners.
14. Health services at Channings Wood at the time the man was there were commissioned by NHS Devon and provided by the Devon Partnership Trust. Since 1 April 2013, health services have been provided by Dorset NHS University Trust. There is no inpatient unit. Nurses are on duty every day. An out of hours GP service is provided by Devon Doctors.

HM Inspectorate of Prisons (HMIP)

15. The last report published on Channings Wood was an announced full inspection between 17 September and 21 September 2012. The report noted that the prison continued to perform reasonably well and the provision of healthcare was satisfactory, but had been disrupted by the absence of a healthcare manager and staff vacancies. Access to nurses and the GP was judged to be reasonable.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board, of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure proper standards of care and decency. The last available IMB annual report for 2011/12 noted that there had been deterioration in the overall performance of healthcare.
17. The IMB concluded:

“The unfamiliarity of temporary medical and nursing staff with both prisoners and prison systems has resulted, in our view, in a failure of prisoners rights (i.e. their right to receive a standard of medical care commensurate with that received by the wider community.) Additionally, it is the belief of the Board that long term medical care, particularly of prisoners presenting with chronic conditions, can slip under the radar as a result of the above problems.”

Previous deaths at HMP Channings Wood

18. In October 2011, a prisoner from Channings Wood died in hospital while restrained by an escort chain to an officer. Since January 2012, there have been four other deaths from natural causes at Channings Wood. Two of these cases also identified similar concerns about the use of restraints.

KEY EVENTS

19. The man was released on licence from Channings Wood prison on 12 June 2012. His licence was revoked on 22 October 2012 and he was recalled to prison at HMP Exeter because he had resumed heavy alcohol use and his behaviour caused concern. He was expected to be released from prison in August 2013.
20. The man had a history of liver problems and had been diagnosed with cirrhosis in April 2012. At his initial health screen at Exeter on 22 October, he told a nurse that he felt terrible because of alcohol misuse and that he had been prescribed venlafaxine, an antidepressant. She noted in the medical record that he had a florid appearance and appeared to be withdrawing from alcohol, so she referred him to the doctor.
21. A doctor saw the man and noted that he had resumed heavy daily alcohol use since his release. She diagnosed that he had chronic alcoholism and planned a 12 day detoxification programme starting the next day. She ordered an ultrasound examination and noted that he might need to be referred to a liver consultant.
22. The next morning, 23 October, a nurse (noted in the medical record as 'other – community health service'), discussed his drinking and the librium¹ treatment with him. Later that day, a nurse examined him and noted that there were no signs of withdrawal evident.
23. On 24 October at 12.36pm, the man told a healthcare manager that he had missed his morning dose of librium as he was afraid of walking down the stairs to pick it up from the treatment room. Although he had no visible tremor, signs of withdrawal or mobility issues, she suggested he asked officers if he could move to a lower landing, but he said he did not want to move. She advised him on the importance of collecting medication and meals and then spoke to officers who agreed to keep an eye on him.
24. At 6.18pm that day, the man was taken ill in his cell and vomited blood. An ambulance was called and paramedics diagnosed a gastric bleed. He was admitted to hospital at 6.40pm. At his request, the Governor contacted his mother who lives in Spain to let her know what had happened.
25. On 30 October, one of the officers escorting the man informed the prison that he had seen him drinking the alcohol hand gel in the hospital toilet. The officer said that he threatened to say the officer had sexually assaulted him if he told anyone about this. There is no further record about this incident.
26. Later that day the man returned to HMP Exeter and was allocated a shared cell on C1 landing and was prescribed 20mg of propranolol. He said that he suffered from post-traumatic stress disorder (PTSD) and needed a single cell. He had been assessed as a standard risk for sharing when he arrived and

¹ Used in the treatment of anxiety and alcoholism

had not previously raised this as an issue. He had been diagnosed at the hospital with a variceal bleed.² It was noted that he needed to have his sodium levels checked in two to three days. On 2 November, the nurse was unable to obtain enough blood to check his sodium levels. He refused a second attempt, and said that he wanted to die.

27. Three days later, on 5 November, the man transferred to Channings Wood. When he arrived he was assessed by a nurse. She noted that he presented well and seemed stable, although she also recorded that he said he had PTSD and seemed very tearful. He said he had flashbacks to when he was serving in the Falklands, so he was referred to the mental health team.
28. On 6 November, the man fell from the top bunk of his bed. He complained of back pain and tenderness in his ribs and was prescribed paracetamol and tramadol (a strong painkiller).
29. On 8 November, the man had a routine endoscopy examination. The consultant determined that there were no signs of bleeding. He decided that he should receive an increased dosage of propranolol and have the test repeated in six months.
30. On 13 November, a psychiatrist considered the man's mental health referral. She noted that he had not mentioned PTSD until he was asked to share a cell. His main problem was alcohol dependency and the severe health complications arising from it. She recorded that he needed to focus on abstinence and that psychological interventions could undermine this. She decided that he should be referred to the substance misuse service (SMS) instead. She noted that he would die from associated physical health problems if he did not stop drinking.
31. A doctor saw the man on 14 November to review him after his fall from the bunk bed. He diagnosed fractured ribs. He did not order an X-ray to confirm the diagnosis, but increased his pain relief to 100mg of tramadol every 12 hours for two weeks.
32. The man was still experiencing pain on 7 December and requested another prescription of tramadol. A doctor prescribed 50mg for a further two weeks and noted that he should be reviewed if there was no improvement. He was prescribed a further course of 100mg of tramadol by a doctor two weeks later.

² a bleed of the vein carrying blood to the liver

2013

33. On 4 January 2013, a doctor saw the man who said that he was still suffering from back pain after falling from his bunk bed in November. He said that he was having difficulty sleeping because of the pain.
34. The doctor spoke to the man about long term liver damage and explained that he was at risk of liver cancer. She suggested that he should have a liver review which could be arranged while he was in prison, but he declined and said he understood the risks involved. He said he would look into it himself after his release. She requested an X-ray (which was booked for 15 January) to try to assess the cause of his back pain. She prescribed 100mg of tramadol every morning for 28 days and 50mg of tramadol each afternoon. The doctor noted that she could not prescribe paracetamol for him because of a possible liver condition.
35. On 14 January, the man went to the healthcare centre suffering from vomiting and diarrhoea. He was advised that he would need to be isolated for at least 48 hours. He was returned to his cell and told healthcare staff would bring his daily medication to him. He was isolated until 19 January, so missed the X-ray arranged for 15 January, which had to be rebooked.
36. On 23 January, the man moved to Mersey Unit. Two days later on 25 January, he had his spine X-rayed. There no evidence of a fracture. It was noted on 9 February that he had settled in well on the unit and was attending a business studies course.
37. On 13 February, a nurse assessed the man's medication and noted that he was prescribed tramadol for back pain. No other problems or issues were recorded in his medical records.
38. The next day, 14 February, the man was examined by a nurse when he complained of general aches and pains, and had a cough. The nurse noted that he appeared dehydrated, that his temperature was high at 39.4 degrees, he had a rapid pulse of 130 a minute and his blood pressure was low at 110/64³. The nurse arranged a doctor's appointment for that afternoon. A wing officer telephoned the healthcare centre at 2.38pm and said that he did not want to attend the appointment.
39. Less than four hours later, the man asked to see a member of healthcare staff again as he still felt unwell. A nurse examined him in the treatment room in healthcare. He complained of heartburn and gastric reflux after eating his dinner, and of general aches and pains. The nurse noted that he had a bloodshot left eye and had a nosebleed in his right nostril. He still had a raised temperature, a high pulse, low blood pressure and low oxygen in his blood. He looked as if he was dehydrated, appeared to be confused and his mobility and coordination were unbalanced. The nurse contacted the out of

³ The normal range for blood pressure is considered to be 120 over 80 and temperature at 37 degrees. The pulse should read between 60 and 100.

hours doctor for further advice. He refused to go to hospital, so a doctor said he would attend the prison. At first he said he did not want to see a doctor but then agreed. At 6.58pm, the doctor examined him and diagnosed pneumonia, mitral valve damage, and sub acute bacterial endocarditis⁴. Although he was reluctant, the doctor persuaded him that he needed to be admitted to hospital.

40. A prisoner at Channings Wood, who was a friend of the man, told the investigator that he believed he had felt ill for several days. He said that, when he saw him on 14 February, he thought that he might die and that he should have been admitted to hospital. The prisoner knew him from Exeter prison and remembered that he had been unwell and had a “massive bleed”. He also recalled that he had fallen from the top bunk of his bed and had been in pain afterwards. The prisoner did not raise his concerns about him with prison staff but said that he had suggested that he should say something himself. He said that he was reluctant to go to hospital because he did not like to be handcuffed.
41. A risk assessment was carried out before the man’s transfer to hospital. His risk to the public, of taking a hostage and potential to escape was recorded as being ‘normal’. He did not have any history of attempting to abscond or of violence. It incorrectly recorded that he had no known instances of alcohol or drug abuse, but noted further in the document that he had been caught drinking hand gel in the hospital toilet on 30 October and that he was considered to be manipulative. The specified risk to the public was that he was on the sex offenders register and was not to have any contact with children. The operational manager who authorised the risk assessment agreed that handcuffs (or an escort chain) should be used and that these should only be removed for emergencies and medical treatment with authorisation of the duty manager.
42. Records indicate that standard handcuffs were applied to the man at 8.10pm. The ambulance left the prison at 8.30pm and arrived at hospital at 8.55pm. At 9.10pm, he was assessed by a doctor in the Accident and Emergency department who requested a blood test and administered intravenous fluids and antibiotics. At 10.00pm, the staff escorting him were told that he would need to be admitted to hospital overnight as he was dehydrated and required further tests. He remained handcuffed until 11.45pm when he had a scan. He returned from a scan at 12.20am, when an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and one to an officer was applied) instead of standard cuffs and he was then admitted to a ward.
43. The next day, 15 February, a prison governor and the prison’s duty manager that day, visited the man in hospital as part of a management check. The duty manager spoke to a nurse, who said there were serious concerns about his health. They were managing him as a ‘life threatening case involving several departments from the hospital, including critical care specialists’. The duty governor was told that his risk of dying was high, but not imminent. It

⁴ inflammation of the heart

was noted in the escort records that a member of hospital staff had contacted his mother in Spain and she had asked to be kept informed of his condition.

44. As she had been told that the man was dying, the duty manager decided that his restraints should be removed. He was not mobile and was attached to medical monitoring equipment. She asked the escorting officers to inform the prison of any change in his condition, so the security risk could be reassessed.
45. On 16 February, the man was transferred to a cardiac ward and his condition had improved slightly. Prison staff were told that he was out of immediate danger. A doctor requested that the escort chain should not be reapplied, because of the need for ongoing medical treatment, but the duty manager asked the escorting officers at the hospital to carry out a risk assessment. She was told that the cardiac ward was on the ground floor, with a number of exits at ground level and that his bed was next to a window and an emergency exit. Although he was still not mobile, officers said he seemed quite alert. Despite the doctor's request, she then authorised him to be restrained by an escort chain. She reminded the officers that they should control the chain so that it did not catch the cannula in his arm.
46. At 9.00pm, the man was moved to a side room, away from the main ward as he was suffering from diarrhoea. The duty manager and a senior officer discussed the security implications and the level of restraints required but agreed that the escort chain should remain in place.
47. Despite the risk assessment, officers noted in the escort log that the man seemed to be 'in a poor way' and 'quite poorly'. He still had a high temperature and although at times seemed lucid at other times he was incoherent and forgetful. He was not mobile enough to use the toilet in the side room, and had a catheter inserted. He remained handcuffed by an escort chain attached to an officer.
48. On 17 February, a hospital doctor told the man that he had an infection, although he could not be sure what was causing it. He began a course of antibiotic medication. He continued to have diarrhoea but managed to drink water and eat some food, although he vomited after eating an orange.
49. The next day, 18 February, the man was shaking and disorientated. Although he was covered by bedclothes, he said he felt very cold. A cardiologist saw him at 10.10am and found that he was confused, weak and out of breath. He told prison staff that he might remain in hospital for up to six weeks. The rest of the morning it was noted that he lay on his bed and was very quiet. Nurses told him that his mother and sister had telephoned to enquire about his health. Arrangements were made to allow him to use the bedside telephone system.
50. During the night the man was moved to the coronary care unit, where he was treated for endocarditis. Officers removed the escort chain while he had surgery to fit a pacemaker. Unfortunately, his condition continued to deteriorate. When officers arrived to relieve the night staff at 6.00am on 19

February, they noted that he was recovering from the surgery and that that escort chain had been reapplied.

51. That morning, the man seemed agitated, unable to settle, was breathless and very hot. At 9.50am, he was treated for fluid on his lungs. At 3.05pm, a doctor told him that his condition was deteriorating rather than improving. The doctor said he wanted to discuss the possibility of heart surgery with a doctor at another hospital, although he did not think that he would be suitable. The doctor told him that the hospital were doing all they could for him but that he was not responding and was dying. The doctor could not say how long he had left to live, but told him that his organs were slowly shutting down. He was reported to appear to take this information very calmly and said he would telephone his mother and ask her to call the hospital for information, which he did.
52. A senior officer noted in the escort log that he had asked the duty governor at 3.05pm for permission to review the risk assessment with a view to removing the escort chain. An operational manager said he would visit the hospital and decide. The man was lying on the bed listening to a radio when, at 4.50pm, his breathing began to sound laboured and slower. He appeared to fall unconscious and the senior officer called for a nurse, who was unable to get a response from him. The senior officer immediately removed the escort chain. No attempt was made by hospital staff to resuscitate him, as his medical notes indicated that he was not to be resuscitated. Five minutes later, at 4.55pm, the nurse pronounced him dead. This was confirmed by a doctor at 5.00pm. The speed at which he died was noted by hospital staff as unexpected.
53. The senior officer told the investigator that the man had remained mobile and had used the toilet shortly before he died. Although he was evidently very poorly, the senior officer had been surprised at how quickly he died. When the duty manager arrived at the hospital he agreed that the senior officer had done the right thing by removing the escort chain.

Staff support

54. The officers who were escorting the man when he died said they had been supported by the prison and an informal hot debrief was held.

Prisoner support

55. Notices informed other prisoners of the man's death, although the man's friend said that unfortunately he had had to break the news to other prisoners who had attended the same business course as they had not received the news at that stage. Prisoners were asked to speak to a member of staff or the chaplaincy if they needed support and a memorial service was held.

Family liaison

56. The duty governor telephoned the man's mother in Spain to let her know that her son had died shortly after the doctor confirmed his death. The next day the Governor at Channings Wood at the time of the man's death, also spoke to her. They discussed funeral arrangements and any assistance the prison could give her. The man's mother agreed that the prison should make the arrangements. The funeral service was held on 8 March, led by the prison chaplain. The prison paid for the funeral in line with Prison Service Instructions. A memorial service was also held at the prison.

Cause of death

57. A post-mortem examination was not carried out, but the Coroner for Torbay and South Devon District confirmed that the man died from blood poisoning and heart and liver disease:

- 1a Sepsis
- 1b Staphylococcal endocarditis
- 2 Hepatitis and cirrhosis.

ISSUES

Clinical issues

58. The man had a history of poor health arising from complications of alcohol abuse. He had been warned by a doctor in January 2013 that he would need tests to determine the extent of liver damage. He refused and said he would look into this himself when he was released from prison. He often did not want to cooperate with medical appointments.
59. Although there were some examples in the man's medical file that some concerns about his condition were not followed up or well-recorded, overall the clinical reviewer is satisfied that he received prompt and appropriate care. Even though he was reluctant to see a doctor when his health deteriorated, staff sought appropriate help and persuaded him to go to hospital. The clinical reviewer notes that:

“despite the vigorous intervention of hospital staff the severity of his illness was such that it did not respond to all medical effort.”

We are satisfied that he received an appropriate standard of healthcare during his time at Channings Wood.

Use of restraints

60. An Ombudsman's report about a prisoner from Channings Wood who died in October 2011, noted that the prisoner was still in restraints in hospital when he died. The report says:
- “It is of considerable concern that, despite being terminally ill, unable to move far from his bed, distressed and short of breath it was considered necessary to keep (the prisoner) on an escort chain up to the moment he died. As a result (the prisoner) was treated in a disrespectful, undignified and inhumane way during his final hours.”
61. Two Ombudsman reports issued in 2012 and 2013 about deaths at Channings Wood also refer to the use of restraints for prisoners being escorted and admitted to hospital. Both reports identified concerns about the appropriateness of the risk assessment and that the prisoners were subject to restraints. In one of the cases, the restraints were removed just a few hours before the prisoner died. In the man's case, he was restrained almost to the point of his death.
62. Although the man's condition frequently changed, at times he was too unwell to leave the hospital bed and his level of lucidity was unpredictable. Prison staff had been told that he was dying, although at the time his death was not expected to be imminent. However, it is clear that he was extremely ill, and that his restraints should have been removed earlier. It is a particular concern that the prison decided to re-apply an escort chain on 16 February, despite a hospital doctor's request that it should be removed to facilitate treatment. At

the time he was very ill, not sufficiently mobile to use the toilet and was supervised by two prison officers.

63. We accept that the man was assessed as a risk to children and had apparently committed a security breach when in hospital before by drinking hand gel, but we are not satisfied that these factors were appropriately balanced against his condition at the time, the medical opinion that he was dying and the hospital doctor's request that the restraints should not be reapplied. The escorting prison officers were sufficiently concerned about him to request that the restraints should be removed two hours before his death yet this was not done.
64. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
65. In the man's case, the restraints remained on almost to the point of death, despite staff being told that he was going to die and after a doctor had requested they should not be used. Although his deterioration was more rapid than expected, we do not consider that using restraints in this way could be regarded as decent or humane.
66. There is a need for the Governor of Channings Wood to ensure that all his staff responsible for escorts and security risk assessments understand that in order for the use of restraints to be lawful there is a need to follow the principles of the High Court judgement and guidance to prisons which was issued after the judgement. We make the following recommendation:

The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

RECOMMENDATION

The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

ACTION PLAN: The Man – HMP Channings Wood

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.	Accepted	Operational managers Band 7 and above, will assess the risk presented by the prisoner at the time of admittance to hospital and at any time risk or assessment of health changes.	July 2013 Completed.	