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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in September  
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, at Torbay Hospital on 9 September, while a prisoner at HMP Channings Wood. The man died from widespread cancer of the bowel and rectum. He was 60 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Channings Wood. The prison cooperated fully with the investigation.

The man was released from prison in May 2008 and then recalled to prison for breaching his licence conditions in April 2009. He transferred to Channings Wood in June that year. He had little interaction with healthcare staff until 19 April 2013, when he complained of abdominal pain. After that, healthcare staff saw the man 13 more times when he continued to report abdominal symptoms, but no one ever carried out a rectal examination. On 14 August, a nurse was concerned about his presentation and arranged for him to be taken to hospital. He was admitted to hospital for tests which indicated he had widespread cancer. The man remained in hospital until his death on 9 September.

The clinical reviewer found that healthcare staff at Channings Wood failed to ensure there was an appropriate and timely diagnosis of the man's condition and concluded that his care fell below that he could have expected to receive in the community. I am concerned that so many health professionals saw the man without identifying the need for further urgent investigation and that his care was poorly coordinated. While earlier diagnosis might not have changed the outcome for the man, it would have allowed appropriate pain relief and care in the weeks leading up to the end of his life.

As in a number of other investigations by my office into deaths of prisoners from Channings Wood, I am concerned that the use of restraints on the man in hospital was not always justified by an individual risk assessment.

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

**April 2014**

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## SUMMARY

1. The man was recalled to prison in April 2009 for breach of his licence conditions after being released from a previous sentence and was sent to HMP Bristol. He transferred to HMP Channings Wood on 1 June 2009.
2. The man had very little interaction with healthcare until he complained of abdominal pain on 19 April 2013 and was referred to the prison GP. The GP saw him ten days later and referred him for an ultrasound scan on 22 May. The scan showed multiple gallstones and bowel gas. The doctor diagnosed irritable bowel syndrome (IBS) and gave the man advice about his diet.
3. Between May and July, healthcare staff saw the man many times when he reported severe abdominal pain. He was prescribed pain relief and laxatives. On 24 July, a doctor made a non-urgent referral to the gastroenterology department of Torbay hospital and requested a blood test. It does not appear that the hospital ever received this referral letter, although prison records indicate it was sent.
4. The doctor reviewed the man's blood test results on 25 July, which were abnormal. As she believed the man had already been referred to hospital she decided no further action was needed.
5. On 14 August, a prison officer was concerned that the man appeared to be in pain. He contacted a nurse who examined him and referred him to the doctor. The doctor saw him at 4.55pm that afternoon and noted that the man had a distended stomach, but did not consider his condition required admission to hospital. At 6.30pm, a nurse examined the man on the wing as he was still in pain. He was concerned at the man's condition and sent him to hospital by emergency ambulance.
6. The man was admitted to hospital and, after tests, was diagnosed with widespread colorectal cancer on 23 August. He remained in hospital until his death on 9 September. The clinical reviewer is concerned that different healthcare professionals at Channings Wood saw the man fourteen times when he complained of abdominal pain, but there is no record that he was ever offered a rectal examination, which should have been standard practice. The clinical reviewer found that healthcare staff at Channings Wood failed to make an appropriate and timely diagnosis. While earlier diagnosis would not have altered the outcome for the man it meant he was in pain for longer than he needed to be. We make recommendations about medical examinations, referral to hospital, continuity of care, risk assessments for using restraints and handling applications for early release on compassionate grounds.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and inviting anyone who had relevant information to contact her. One prisoner contacted her as a result.
8. The investigator obtained copies of the man's relevant prison and prison medical records. She visited HMP Channings Wood on 22 November and interviewed three members of staff and one prisoner. The investigator gave feedback on the preliminary findings of the investigation, and followed this up in writing.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. The investigator informed HM Coroner for Torbay and South West District of the investigation and the Coroner provided the cause of death. A post-mortem examination was not conducted. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's son, to explain the purpose of the investigation. The man's son had no specific concerns for the investigation to consider.
12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, his location, liaison with his family, whether compassionate release was considered; and security arrangements for escort and bedwatch.
13. The Ombudsman's family liaison officer wrote to the man's son, after being unsuccessful in making telephone contact. This was to offer him the chance receive a copy of the draft version of the investigation report, to date we have received no further contact. I hope that the findings of my investigation answer any questions the man's family may have, should they receive the report in the future.

## **HMP CHANNINGS WOOD**

14. HMP Channings Wood is a category C training prison near Newton Abbot in Devon. It holds over 700 convicted male adult prisoners.
15. Dorset NHS University Trust provided health services at the prison. There is no inpatient unit. There is one permanent GP and locum GPs run other clinics. Nurses are on duty everyday. The Torbay consortium provides an out of hours GP service.

## **HM Inspectorate of Prisons**

16. The most recent inspection of Channings Wood was in September 2012. The Inspectorate noted that healthcare staff were generally helpful and respectful, although many prisoners were unhappy with the support provided by healthcare staff. Prisoners had reasonably good access to nurses and the GP and urgent problems could be dealt with on the same day. There were delays for some other clinics and chronic disease management was not always systematic. Inspectors found that some very sick prisoners were inappropriately restrained in hospital.

## **Independent Monitoring Board**

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to August 2013, the IMB notes that healthcare was under new management and that after five months the initial signs were positive, with improved doctor continuity and staffing numbers. The IMB also noted that there was improved pain relief and healthcare for older prisoners.

## **Previous deaths at HMP Channings Wood**

18. There have been nine deaths from natural causes at Channings Wood since 2010. In a number of cases, we made recommendations about the need to ensure that the use of restraints in hospital is justified by an individual risk assessment.

## ISSUES

### The diagnosis of the man's terminal illness and informing him of his condition

19. From the time he was recalled to prison in April 2009, the man had little contact with healthcare until 19 April 2013 when he complained of abdominal pain to a nurse. He said that he had previously suffered with gallstones and the nurse referred him to the prison doctor.
20. Ten days later, the doctor examined the man who said he was suffering with right-sided abdominal pain and had found blood in his urine. The man was not in pain when she saw him and she could find no abnormalities. The doctor referred him for an ultrasound scan and blood tests. The clinical reviewer said that this was an appropriate initial route of investigation.
21. The doctor saw the man on 30 May to discuss the results of his scan and blood test. She diagnosed the man with irritable bowel syndrome, prescribed medication and gave him dietary advice.
22. When interviewed. The doctor said she had diagnosed irritable bowel syndrome by exclusion, meaning that she had discounted all other likely causes of his symptoms. She explained that the man had not presented with any 'red flag' symptoms such as rectal bleeding, weight loss or altered bowel habits, which would have triggered a suspicion of bowel cancer.
23. The doctor saw the man again on 13 June when he complained of pain when urinating. A urine test showed nothing abnormal.
24. On 10 July, a Mental Health Nurse saw the man who said he was experiencing continuing abdominal pain and constipation. The mental health nurse prescribed pain relief and senna (an oral laxative).
25. The man's symptoms continued and healthcare staff saw him a number of times. On 16 July, the doctor examined him and noted that she could find no obvious abdominal masses but she did not suggest a rectal examination. Records show that this was the eighth time in eleven weeks that healthcare staff had seen the man. The clinical reviewer commented that it should be standard practice to perform a rectal examination in a person presenting with abdominal pain and constipation
26. The doctor explained that she had thought that the change in the man's bowel habit could have been related to the dietary change she had recommended. His weight was not recorded but the doctor said that the man had no reported weight loss. She recalled that the man had declined a rectal examination but there is no record of this in his medical notes.
27. A nurse saw the man on the evening of 23 July because he was complaining of long standing pain and had a slight fever. The nurse advised him to see a doctor the next day. A locum GP reviewed the man the next morning and was unable to find any obvious abdominal mass. She did not carry out a rectal

examination. When interviewed, the GP agreed that with hindsight that this should have been offered.

28. The GP requested blood tests and made a non-urgent referral to the gastroenterology department at Torbay Hospital. In her referral letter the GP wrote, "on examining him [the man] there is nothing to find and I am sure he has IBS. However, he is so concerned about himself that I would be grateful for your opinion". She prescribed the man further laxatives and pain relief.
29. The doctor reviewed the man's blood test results on 25 July. The tests showed that his protein levels were above normal and that his white blood cell count was abnormal. The doctor was aware that the man had been referred to the gastroenterology department so, despite the abnormal blood results, decided that no further action was needed. The doctor explained that she considered the raised protein levels might have been caused by irritable bowel symptoms. The clinical reviewer commented that an abnormal white blood cell count should have raised serious concerns and in someone with symptoms such as the man it could indicate an intra-abdominal abscess or malignancy. The clinical reviewer said that none of the blood results supported a diagnosis of irritable bowel syndrome which the doctor had diagnosed when an ultrasound scan for possible gallstones was normal and there were no red flags. The doctor said that when she made the diagnosis there was no alteration in bowel habit and the symptoms had not been present very long.
30. The clinical reviewer found that the diagnosis of IBS was not appropriate and that the doctor did not follow the National Institute for Health and Clinical Excellence (NICE) guidance for the diagnosis and treatment of irritable bowel syndrome. We make the following recommendation:

**The Head of Healthcare should ensure that prison doctors follow NICE guidelines for the diagnosis and treatment of irritable bowel syndrome and offer rectal examinations for all prisoners with abdominal pain and constipation.**

31. On 29 July, the doctor saw the man to discuss his blood results with him. She noted in his medical records he was waiting for a gastroenterology appointment and that his blood pressure was slightly raised. The doctor asked that the man be reviewed in two weeks. The clinical reviewer is concerned that the doctor did not review the referral when the abnormal blood test results were received to consider whether an urgent two week referral for suspected cancer was appropriate. (Under national NHS guidelines, any cases of suspected cancer should be referred to a specialist and the patient should wait a maximum of two weeks before being seen.) We make the following recommendation:

**The Head of Healthcare should ensure that prisoners are referred urgently to specialists whenever test results show abnormalities which might indicate cancer.**

32. On 12 August, healthcare assistant reviewed the man at the request of prison staff who were concerned at the amount of pain he was suffering. She asked the prison doctor to see the man. Another locum GP saw the man later that afternoon and prescribed powerful laxatives and suppositories. The man was waiting for a hospital referral made on 24 July. Unfortunately, there is no record in the hospital notes of a letter requesting a gastroenterology appointment ever being received so no outpatient appointment was made. While ideally this would have been chased up, we recognise that three weeks is not so long to wait to be informed of an appointment date for a routine referral. Had it been longer we would have expected the healthcare staff to have checked with the hospital.
33. On 14 August, an officer found the man bent over in pain. The man said that the treatment he had been given was not working. The officer contacted healthcare staff and a nurse examined the man at 4.20pm that afternoon. She found his abdomen was hard and very swollen. The man said that he had been unable to open his bowels properly for four months. The nurse attempted to give the man an electrocardiogram (ECG) (a test to record the rhythm and electrical activity of the heart) but due to the pain he was in this was not possible. At 4.55pm the same day, a doctor examined the man and found that his abdomen was swollen. She noted the abnormal blood results in his medical record and asked that the man be booked in for a non-emergency GP appointment for further review.
34. The doctor told the investigator that when she examined the man she could find no reason for an acute or surgical admission to hospital. She said that the man's ongoing abdominal problems were chronic, but worsening, and required a further review before possible diagnosis or referral to hospital.
35. A nurse was called to see the man on the wing at 6.30pm the same evening, and found him in tears and in considerable pain, ashen in colour and "clearly bloated". A nurse arranged for the man to be taken to hospital by emergency ambulance.
36. At hospital, the gastroenterology team reviewed the man. He had an X-ray and CT scan of the abdomen and tissue biopsy. A consultant clinical oncologist saw the man on 23 August and diagnosed widespread colorectal cancer. (Colorectal cancer is a cancer from uncontrolled cell growth in the colon or rectum).
37. On 28 August, the hospital palliative care team saw the man and informed him that due to the advanced stage of his cancer he was not able to have chemotherapy. His cancer could not be cured and only palliative treatment was possible. His life expectancy was predicted at between two days to two weeks. The man remained in hospital and his health continued to deteriorate. He died in hospital at 11.05am on 9 September.
38. The clinical reviewer states that healthcare staff at Channings Wood repeatedly failed to ensure the man had an appropriate and timely diagnosis. The man did not have a rectal examination until his admission to hospital,

despite presenting with abdominal symptoms on at least 14 occasions to differing health care staff. The clinical reviewer says a rectal examination is a fundamental part of a full abdominal examination. The clinical reviewer also states that, given the extent of the man's condition, an earlier diagnosis would not have prevented his death but might have allowed better care and pain control at an earlier stage.

39. We are concerned that some of these failings arose from a lack of effective continuity of care between the various healthcare staff who saw the man. Both doctors said that a lack of continuity of care contributed to the delay in diagnosis. We make the following recommendation:

**The Head of Healthcare should ensure that there is adequate continuity of care and that so far as possible prisoners with ongoing health problems are seen by the same doctor.**

### **The man's medical treatment**

40. The man first complained of abdominal pain on 19 April 2013. He was prescribed simple pain relief but not regularly.
41. After continued abdominal symptoms, the doctor referred the man to the gastroenterology department at Torbay Hospital on 24 July. However, the referral letter was never received by the hospital and no outpatient appointment made.
42. On 14 August, the man was admitted to Torbay Hospital where he was subsequently diagnosed with widespread colorectal cancer. After his admission, his treatment was the responsibility of the hospital, but it is apparent that hospital staff kept him fully informed of his diagnosis, prognosis and care.
43. The clinical reviewer notes that before his diagnosis the man had weeks of pain which disrupted his sleep and distressed him. Despite it being noted that the pain was preventing him from sleeping there is no evidence that consideration was given to treating his pain effectively. Again this was not helped by a lack of continuity of care. The clinical reviewer says that "the man's analgesia [pain relief] needs were not met, and he suffered unnecessarily as a result." We make the following recommendation:

**The Head of Healthcare should ensure that prisoners suffering from pain receive effective analgesia.**

### **The man's location**

44. On 2 September, the man enquired about a move from hospital to a hospice nearer to his home. The hospital palliative care team agreed to look into this

on his behalf. As hospital care is outside the remit of the Prisons and Probation Ombudsman we are unable to discover if this was done, although there is no record that prison staff were involved (which they would need to have been).

45. A multidisciplinary meeting was held on 3 September to discuss a possible move from the hospital to the palliative care suite at HMP Exeter for the man's end of life care. On Friday 6 September, the man agreed that he would move to Exeter. An ambulance was arranged to transfer him on 9 September. However, his condition deteriorated over the weekend and he died at 11.05pm that day.

### **Restraints, security and escorts**

46. 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 also deemed that restraining by handcuffs of 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.
47. The man was taken by emergency escort to Torbay hospital on 14 August 2013. He was escorted by two prison officers and restrained by a single handcuff. His risk assessment noted he was considered a low risk to the public and of escape. The papers referred to a previous escape from prison (in 2005) and his conviction for violent offences, but there is no evidence that the man's state of health was taken into account.
48. At hospital the handcuff was removed and replaced with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) His risk assessment was reviewed the next day and raised from low risk to normal and the level of restraints remained unchanged. There is no explanation for the assessment that his level of risk had increased, and again no evidence that his health was taken into account.
49. On 22 August, the man's risk assessment was reviewed and after receiving medical advice the escort chain was removed.

50. Records show that the man remained restrained by an escort chain from 15 until 22 August. He was assessed as having some mobility and therefore a risk of potential escape.
51. The man was 60 years old, with reduced mobility and his condition had deteriorated. He was also connected to a morphine pump to self-administer pain relief. While his offences were of a serious nature, the circumstances would not suggest that he was a current risk to the general public. He had previously absconded from an open prison, but that was in 2005. Until 22 August, when the restraints were removed, there is no evidence that the risk assessments for the use of restraints took fully into account medical evidence about how his condition impacted on his ability to escape as the court judgement required. We make the following recommendation:

**The Governor should ensure that risk assessments for prisoners taken to hospital take into account individual circumstances including their health and mobility and are based on the actual risk the prisoner presents at that time**

#### **Liaison with the man's family**

52. The man was estranged from his family and did not initially want them to be contacted during his illness. On 30 August, following a conversation with the prison's family liaison officer, he agreed that she could get in touch with his family. The family liaison officer contacted the man's son, his nominated next of kin, on 30 August and his family visited him in hospital on several occasions. They were with him when he died.

53. In line with national policy the prison contributed towards funeral costs.

#### **Compassionate release**

54. Release on compassionate grounds is a means by which prisoners that 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 for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending 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. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
55. An application for early release on compassionate grounds was initiated on 29 August by a probation officer at the prison. However, the application was not completed until the 9 September, the day the man died. A doctor recorded that the man was now in the terminal phase of his illness and the Governor commented that a hospice would be an appropriate option for the man.

56. As the man had been given a life expectancy of from two days to two weeks on 1 September, we are concerned about the length of time it took to complete the application which made it unlikely that a decision would have been made before the man died. The Head of Security at Channings Wood, explained that no-one was in charge of co-ordinating the application for compassionate release which explained why it took twelve days to complete and the man died before it was finalised. We make the following recommendation:

**The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that prison doctors follow NICE guidelines for the diagnosis and treatment of irritable bowel syndrome and offer rectal examinations for all prisoners with abdominal pain and constipation.
2. The Head of Healthcare should ensure that prisoners are referred urgently to specialists whenever test results show abnormalities which might indicate cancer.
3. The Head of Healthcare should ensure that there is adequate continuity of care and that so far as possible prisoners with ongoing health problems are seen by the same doctor.
4. The Head of Healthcare should ensure that prisoners suffering from pain receive effective analgesia.
5. The Governor should ensure that risk assessments for prisoners taken to hospital take into account individual circumstances including their health and mobility and are based on the actual risk the prisoner presents at that time.
6. The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay.

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prison doctors follow NICE guidelines for the diagnosis and treatment of irritable bowel syndrome and offer rectal examinations for all prisoners with abdominal pain and constipation.	Accepted	All Healthcare staff (Doctors and nurses) follow NICE guidance for the early diagnosis and treatment for IBS and the early identification of cancer diagnosis. A clinical audit will take place in July (and annually thereafter) to ensure these standards are being met.	July 2014	
2	The Head of Healthcare should ensure that prisoners are referred urgently to specialists whenever test results show abnormalities which might indicate cancer.	Accepted	All Healthcare staff follow agreed protocols and pathways for urgent referrals to specialist secondary care services. This process will be audited annually to ensure appropriate standards are being met (the next audit will take place in July).	July 2014	
3	The Head of Healthcare should ensure that there is adequate continuity of care and that so far as possible prisoners with ongoing health problems are seen by the same doctor.	Accepted	Dorset Healthcare NHS University Foundation Trust has implemented a robust workforce strategy to enable HMP Channings Wood to have a regular and consistent medical service. In the absence of a regular staff member, local	July 2014	

			cover will continue to be drawn from a regular pool of staff. This process will be reviewed annually (the next review will take place in July).		
4	The Head of Healthcare should ensure that prisoners suffering from pain receive effective analgesia.	Accepted	Assessments to determine a patient's appropriate pain control requirements will continue to be based on their physical health presentation at the time of assessment. This process will be audited annually to ensure appropriate standards are being met (the next audit will take place in July).	July 2014	
5	The Governor should ensure that risk assessments for prisoners taken to hospital take into account individual circumstances including their health and mobility and are based on the actual risk the prisoner presents at that time.	Accepted	Duty Governors have been briefed on the need for security risk assessments to reflect a prisoner's actual risk presented at the time of assessment.  All escort risk assessments will be considered by the Head of Security and Operations or the Duty Governor to determine current risk factors (including whether the use of restraints is required), and risk documentation will be amended to	April 2014	

			<p>include a section to accurately record the reasons for the use of restraints when a decision is made that this action is appropriate.</p> <p>The risk presented by prisoners who remain at outside hospital will be reviewed daily, or sooner if there is a change in their condition.</p>		
6	<p>The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay.</p>	Accepted	<p>The nominated person will now be the Offender Supervisor, or an alternative Offender Supervisor if they are not available.</p> <p>Instructions to staff will be published to outline their responsibilities.</p>	April 2014	