Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Lee-Channing, a prisoner at HMP Leicester, on 9 April 2020

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
F I 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Lee-Channing died in hospital of COVID-19 pneumonia on 9 April 2020, while a prisoner at HMP Leicester. He was 58 years old. I offer my condolences to Mr Lee-Channing's family and friends.

The clinical reviewer concluded that the healthcare Mr Lee-Channing received at Leicester was equivalent to that which he could have expected to receive in the community. Staff appropriately treated his underlying health conditions and shielded him from 19 March.

However, I am concerned that on 27 March, Mr Lee-Channing was given a new cellmate who had been in the community before arriving at Leicester on 17 March, and who had shared a cell with three different prisoners during his ten days in the prison's induction unit. While we cannot say whether Mr Lee-Channing contracted COVID-19 from his cellmate, we consider that the decision to place a newly arrived prisoner into Mr Lee-Channing's cell would have put him at unnecessary risk.

I am also concerned that the decision to restrain Mr Lee-Channing when he was taken to hospital was made without any input from healthcare staff on his current condition. There was also a delay in telling Mr Lee-Channing's family that he was seriously ill in hospital.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2021**

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Summary

Events

1. On 10 February 2020, Mr David Lee-Channing was remanded in prison custody, charged with sexual and violent offences, and sent to HMP Leicester.

2. Mr Lee-Channing had several health conditions including frontal lobe atrophy disease (a type of dementia), hypertension (high blood pressure) and Type 2 diabetes.

3. On 9 March, Mr Lee-Channing went to hospital for an outpatient appointment.

4. On 19 March, the prison began shielding Mr Lee-Channing and his cellmate in their cell in response to the COVID-19 pandemic. On 26 March, Mr Lee-Channing's cellmate left Leicester. The next day, Mr Lee-Channing was given a new cellmate, who had just spent ten days in the induction unit at Leicester and had shared a cell with three different prisoners while there.

5. On 4 April, a nurse saw Mr Lee-Channing, who said that he felt lethargic, had aching muscles and had had a dry cough for a few days. The nurse took Mr Lee-Channing's basic observations and found that his temperature was normal. Due to his cough, the nurse created a COVID-19 care plan, which instructed staff to isolate Mr Lee-Channing for seven days, to review his underlying health needs, to review him daily and to send him to hospital if his condition deteriorated.

6. On 5 April, a nurse saw Mr Lee-Channing and found that his temperature was high and his blood oxygen saturation level was low. Ambulance paramedics, who were in the prison dealing with another prisoner, checked on Mr Lee-Channing and decided that he did not need to go to hospital.

7. On 7 April, a nurse saw Mr Lee Channing, who said that he felt unwell. The nurse took his basic observations, which were abnormal. She thought Mr Lee-Channing might have COVID-19 and sent him to hospital.

8. Shortly after arriving at hospital, Mr Lee-Channing was admitted to the resus unit. He subsequently tested positive for COVID-19. Mr Lee-Channing's condition continued to deteriorate and he died at 10.30am on 9 April.

9. A hospital doctor recorded that Mr Lee-Channing's death was caused by COVID-19 pneumonia, with diabetes and hypertension as contributory factors.

Findings

Clinical care

10. The clinical reviewer concluded that the healthcare Mr Lee-Channing received at Leicester was equivalent to that which he could have expected to receive in the community. Staff treated his underlying health conditions appropriately and they shielded him from 19 March. However, the clinical reviewer found that healthcare staff had not created a care plan to monitor his diabetes.

Management of Mr Lee-Channing's risk of contracting COVID-19

11. We cannot be sure whether Mr Lee-Channing contracted COVID-19 in prison, perhaps from his new cellmate, or when he went to hospital as an outpatient on 9 March. However, although there was no policy in place at that time to prevent Leicester moving a newly arrived prisoner into the cell of a shielding prisoner, we consider that doing so showed poor judgement and put Mr Lee-Channing at unnecessary risk.

Restraints, security and escorts

12. We do not consider that the use of restraints was justified when Mr Lee-Channing was taken to hospital given his poor mobility and state of health. We are concerned that a member of healthcare staff did not complete the medical information section of the escort risk assessment and a senior prison manager, therefore, authorised restraints based on incomplete information. We are also concerned that restraints were not removed when a hospital doctor said that their use unnecessarily increased the exposure to COVID-19 for the escorting officers.

Liaison with Mr Lee-Channing's family

13. There was a delay in the prison telling Mr Lee-Channing's family that he had been admitted to hospital. Also, significant discussions between the prison's family liaison officer and his family were not recorded in the family liaison log.

Recommendations

- The Head of Healthcare should ensure that healthcare staff create care plans for all prisoners with diabetes.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
  - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
  - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

- The Governor should ensure that:
  - a senior manager is informed whenever a healthcare professional requests the removal of restraints; and
  - the reasons are recorded if the request is not agreed.
- The Governor should ensure that all staff who act as Duty Governor have received the necessary training to perform the role.
- The Governor should ensure, in line with PSI 64/2011, that:
  - staff notify a prisoner's next of kin as soon as possible when they become seriously ill; and
  - every contact with the next of kin is recorded in the family liaison log.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Lee-Channing's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Lee-Channing's clinical care at the prison.

17. The investigator interviewed seven members of staff at HMP Leicester on 8, 9, 10 and 11 June 2020. The clinical reviewer joined the investigator for the four interviews on 8 and 9 June. All the interviews were conducted by telephone because of the restrictions imposed as a result of COVID-19.

18. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. She gave us the cause of death as determined by a doctor from Leicester Royal Infirmary. We have sent the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Lee-Channing's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider.

20. Mr Lee-Channing's daughter responded and said that her father had had a high temperature and a cough for three weeks before he died but nothing was done to help him. She was concerned that a newly arrived prisoner had not been isolated properly before being moved into Mr Lee-Channing's cell. She was also concerned that Mr Lee-Channing had not been tested for COVID-19 earlier, or sent to hospital sooner.

21. We have addressed these points in this report and in the clinical review.

22. We sent a copy of our initial report to HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. However, we did agree to remove one of our recommendations after HMPPS made representations that changes had been introduced shortly after Mr Lee-Channing's death to keep newly arrived prisoners separate from the rest of the prison. HMPPS provided an action plan which is annexed to this report.

23. We shared a copy of our initial report with Mr Lee-Channing's daughter. She repeated her concerns about the care her father received but did not identify any factual inaccuracies.

Background Information

HMP Leicester

24. HMP Leicester is a local prison that holds 350 men. The prison serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Nottinghamshire Healthcare NHS Foundation Trust provides 24-hour healthcare services at the prison.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Leicester was in January 2018. Inspectors reported that healthcare at the prison had improved, although there were notable staff vacancies, which were filled with agency staff. Inspectors found that patients with long-term conditions were identified during their reception screening and a GP managed their care.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2020, the IMB reported that the healthcare department continued to deliver a very good service, with little reliance on agency staff or locums. They also reported that in April 2019, external contractors completed a deep clean of the healthcare accommodation to meet infection control standards.

Previous deaths at HMP Leicester

27. Mr Lee-Channing was the seventh prisoner to die at Leicester since April 2018. Two of the previous deaths were from natural causes, three were self-inflicted and one was drug-related. There are no similarities between this investigation and previous deaths at Leicester.

28. There have been no other COVID-19 related deaths at Leicester.

Coronavirus (COVID-19)

29. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

30. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

31. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

32. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

33. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were to be identified and put into protective isolation.

34. On 31 March, HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation' were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included:

    - Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
    - Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff.
    - Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population. These units could also accommodate any one returning from hospital.

Key Events

35. On 10 February 2020, Mr David Lee-Channing was remanded in prison custody, charged with sexual and violent offences, and sent to HMP Leicester.

36. At his initial health assessment Mr Lee-Channing said he had frontal lobe atrophy (a type of dementia which caused him to have problems with his memory), hypertension (high blood pressure), Type 2 diabetes, anxiety and depression. He was also suspected to have an, as yet, undiagnosed neurological condition. Mr Lee-Channing's diabetes was diet-controlled but his other conditions were treated with medication,

37. Mr Lee-Channing told a prison GP that his "brain problem" made him unsteady on his feet and unable to care for himself, and that he used a wheeled walker to get around. She noted that he walked with a shuffling gait.

38. A healthcare support worker created a social care plan, which provided Mr Lee-Channing with support for all his daily living activities.

39. On 28 February, a prison GP saw Mr Lee-Channing. The GP found that he had a slow heart rate and that his blood pressure was high. He referred him for a blood test and an ECG (a test to check the heart's rhythm and electrical activity). They produced normal results and no further action was required.

40. On 5 March, a nurse saw Mr Lee-Channing, who complained that he had a headache although he was not dizzy or nauseous. A nurse took Mr Lee-Channing's basic observations and found his heart rate was low, though his temperature was normal at 36.1°C (a symptom of COVID-19 is a temperature of 37.8°C or above). She told Mr Lee-Channing to drink more and rest.

41. On 9 March, Mr Lee-Channing was seen as an outpatient by the neurology team at Leicester Hospital. The neurologist confirmed that Mr Lee-Channing had frontal lobe atrophy, which had caused a change in his personality. He also found that Mr Lee-Channing was struggling with mild stiffness, an early suggestion of Parkinson's Disease.

42. On 19 March, the prison and the healthcare department decided to create a small shielding unit for prisoners with underlying health conditions that made them vulnerable to COVID-19. Mr Lee-Channing was located in one of the cells in the shielding unit.

43. On 23 March, a nurse saw Mr Lee-Channing at the request of prison staff. Mr Lee-Channing said that he had woken in the night shaking but was unsure if he was cold. The nurse took Mr Lee-Channing's basic observations and found that his blood pressure was high and his heart rate was low, though his temperature was normal at 36.7°C. She decided to check Mr Lee-Channing's blood pressure the following day and asked staff to make sure that he had enough blankets. There is no record that anyone checked Mr Lee-Channing's blood pressure on 24 March.

44. On 26 March, Mr Lee-Channing's cellmate was moved to another prison. The following day, Mr Lee-Channing was given a new cellmate, who had arrived at

Leicester from the community on 17 March, and had shared a cell with three different prisoners during his ten days in the prison's induction unit.

45. On 29 March, a nurse saw Mr Lee-Channing who complained of having a "tickly" cough, though it was not new or continuous. The nurse took his temperature, which was normal at 36.1°C.

46. On 2 April, a healthcare support worker noted in Mr Lee-Channing's electronic medical record that his partner had contacted the prison because she was concerned that he did not have access to showers, medication and letters, and was being kept in his cell. She spoke with prison staff, who told her that, although the prison was on lockdown due to COVID-19, Mr Lee-Channing had been offered regular access to showers, phone calls and exercise.

47. On 4 April, a nurse saw Mr Lee-Channing, who said that he felt lethargic, had aching muscles and had had a dry cough for a few days. She took his basic observations and found that his blood pressure was high, though his temperature was normal at 36.7°C. Due to his cough, the nurse created a COVID-19 care plan, which instructed staff to isolate Mr Lee-Channing for seven days, to review his underlying health needs, to review him daily and to send him to hospital if his condition deteriorated.

48. On 5 April, a nurse saw Mr Lee-Channing as he had COVID-19 related symptoms, and took his basic observations. His temperature was high at 39.3°C and his blood oxygen saturation was low at 92% (a normal oxygen saturation rate is between 95 and 100%).

49. Later that afternoon, a nurse saw Mr Lee-Channing and took his basic observations. His blood pressure and respiratory rate were high, and his blood oxygen saturation level was low at 94%, though his temperature was normal at 37.0°C. The nurse gave him oxygen and paracetamol and asked paramedics, who were examining another prisoner, to review Mr Lee-Channing. Paramedics reviewed him and decided that he did not need to be taken to hospital as his basic observations had improved.

50. On 6 April, a nurse saw Mr Lee-Channing and took his basic observations after he fell out of bed. His blood oxygen saturation level was low at 90%, though it returned to normal after five minutes of oxygen, and his temperature was normal at 36.8°C.

51. Later that afternoon, a nurse saw Mr Lee-Channing, as he felt dizzy. She took his basic observations. His blood pressure was high, though his oxygen saturation and his temperature were normal, at 95% and 36.4°C respectively. She added Mr Lee-Channing to the triage list to be checked the following day.

52. At 11.45am on 7 April, a nurse saw Mr Lee Channing and immediately noted that he was breathing rapidly. She took his basic observations. His respiratory rate, blood pressure and temperature were high (38.5°C), and his blood oxygen saturation level was low at 88%. She thought Mr Lee-Channing might have COVID-19 or a chest infection and, at 12.17pm, asked for an ambulance to take him to hospital.

53. At 1.15pm, paramedics took Mr Lee-Channing to Leicester Royal Infirmary. Two prison officers accompanied Mr Lee-Channing and restrained him 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).

54. When Mr Lee-Channing arrived at Leicester Royal Infirmary, hospital doctors tested him for COVID-19. At 8.40pm, he was moved to the resus unit because his breathing had deteriorated. A hospital doctor asked the escorting officers to locate themselves outside the unit to limit unnecessary exposure to COVID-19. To allow this, an officer asked for permission to remove the escort chain, but the senior manager refused. She told the investigator that this was because Mr Lee-Channing was only suspected of having COVID-19 at this point.

55. At 11.55pm, a hospital doctor planned to move Mr Lee-Channing to an isolation room and told the escorting officers that they needed to remove the escort chain. An officer asked for permission to remove the escort chain and the senior manager authorised this. She told the investigator that this was because, since the earlier request, Mr Lee-Channing had been confirmed as having COVID-19.

56. At 1.10pm on 8 April, a nurse told an escorting officer that Mr Lee-Channing was approaching the end of his life. At 3.34pm, a nurse noted in Mr Lee-Channing's electronic medical record that he had tested positive for COVID-19. Mr Lee-Channing's condition continued to deteriorate and he died at 10.30am on 9 April.

Contact with Mr Lee-Channing's family

57. On 8 April, the prison appointed a family liaison officer (FLO).

58. At 9.30am on 9 April, the FLO telephoned Mr Lee-Channing's partner and updated her on his current condition. The FLO said that she would telephone Mr Lee-Channing's partner again with a further update. Two hours later, the FLO telephoned Mr Lee-Channing's partner to break the news of his death and offered her condolences and support.

59. The FLO continued to support Mr Lee-Channing's partner until his funeral, which was held on 1 May 2020. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

60. After Mr Lee-Channing's death, a senior manager debriefed the escorting officers to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

61. The prison posted notices informing other prisoners of Mr Lee-Channing's death, and offering support. Chaplaincy staff spoke with his cellmate and told him of Mr Lee-Channing's death. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lee-Channing's death.

Cause of death

62. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was carried out. A hospital doctor recorded that Mr Lee-Channing's death was caused by COVID-19 pneumonia, with Type 2 diabetes and hypertension as contributory factors.

Findings

Clinical care

63. The clinical reviewer found that overall, the standard of healthcare that Mr Lee-Channing received at Leicester was equivalent to that he could have expected to receive in the community.

64. Mr Lee-Channing had several underlying health problems, including hypertension and diabetes, when he arrived at Leicester. The clinical reviewer noted that healthcare staff quickly recognised his conditions and put appropriate measures in place. He was seen by the mental health team and reviewed by a psychiatrist who concurred with the diagnosis of frontal lobe atrophy. Healthcare staff put a support package in place to ensure Mr Lee-Channing was able to manage his day to day needs and his cellmate acted as a 'buddy' (a prisoner who helps with everyday tasks).

65. However, the clinical reviewer considered that, although Mr Lee-Channing's diabetes was diet-controlled and a diabetes review would have been routinely completed every six months, healthcare staff should have created a diabetes care plan for regular monitoring. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff create care plans for all prisoners with diabetes.

Management of Mr Lee-Channing's risk of contracting COVID-19

66. The clinical reviewer is satisfied that healthcare staff at Leicester were aware of the procedures required in the prison for the COVID-19 pandemic and specifically for prisoners need for isolation, cohorting and the wearing of PPE. Leicester followed the shielding guidelines at the beginning of the pandemic, and identified and isolated those prisoners with underlying health conditions in the week of 19 March. Mr Lee-Channing was appropriately identified and shielded, along with his cellmate, from 19 March.

67. Testing capacity was limited at the time Mr Lee-Channing became ill. However, as the staff had been told to treat everyone with symptoms as if they were positive with COVID-19, this did not adversely affect the delivery of Mr Lee-Channing's care. When he began to show symptoms of clinical deterioration he was admitted as an emergency to hospital.

68. However, we share the clinical reviewer's concern that when Mr Lee-Channing's cell mate left prison on 26 March, after the shielding process had begun, prison staff moved a new cell mate in on 27 March who had very recently been in the community and who had previously shared a cell with three other prisoners who had recently been in the community.

69. HMPPS guidance, *Cohorting guidance for prisons during the COVID-19 period*, published on 31 March, introduced Reverse Cohorting Units, Protective Isolation Units and Shielding Units to reduce the likelihood of COVID-19 spreading through the prison system. Reverse cohorting requires newly arrived prisoners

to be kept separate, for up to 14 days, to detect anyone with COVID-19 symptoms.

70. As the cohorting guidance was not introduced until 31 March, there was no policy on 27 March to prevent prison staff moving a newly arrived prisoner into Mr Lee-Channing's cell. However, we consider that this showed poor judgement. It made no sense to shield Mr Lee-Channing because his medical conditions made him vulnerable to COVID-19 and then place him in a cell with a prisoner who had very recently been in the community. We have seen no evidence that a risk assessment was undertaken before this decision was made or that healthcare staff were involved in the decision-making.

71. The prison had an early spike in COVID-19 cases, with the first prisoner testing positive on 21 March, and at one point there were 20 symptomatic prisoners. In addition, out of the 28 healthcare staff, 16 had been self-isolating at home with symptoms. We cannot say with certainty whether Mr Lee-Channing contracted COVID-19 in prison since he would also have come into contact with a variety of people when he went to hospital as an outpatient on 9 March. However, putting him in close contact with a prisoner who had been in the community ten days earlier and who had shared with three other newly arrived prisoners, clearly increased his risk of contracting the virus.

72. As we are satisfied that Leicester now has a Reverse Cohorting Unit, which keeps new prisoners separate from the rest of the prison for up to 14 days, we do not make a recommendation.

Restraints, security and escorts

73. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility.

74. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

75. HMPPS guidance, *COVID-19 – External Escorts and Bedwatches Security*, published on 27 March, provides advice on making effective security decisions when escorting prisoners who are suspected of or confirmed as having COVID-19. This includes that the risk assessment should pay particular attention to any relevant COVID-19 issues and that if medical staff advise that restraints are impeding treatment then escorting staff must contact the prison for permission to remove them.

76. We are concerned that when Mr Lee-Channing went to hospital on 7 April, no one from healthcare completed the medical information section of the escort risk

assessment form. Without information on Mr Lee-Channing's medical condition, including that he was suspected of having COVID-19 and had poor mobility and used a wheeled walker, the senior manager was unable to make an informed decision on whether restraints were justified. Although the senior manager told the investigator that this information was highly unlikely to alter his decision, we consider that the use of restraints, in addition to two escorting officers, was not justified when Mr Lee-Channing was taken to hospital.

77. Mr Lee-Channing remained in restraints for 12 hours after he was taken to hospital. At 8.40pm that night, one of the escorting officers wrote in the Bed Watch Log that hospital doctors had moved Mr Lee-Channing to the resus unit and had asked the escorting officers to locate themselves outside the unit to limit unnecessary exposure to COVID-19. An escorting officer therefore asked for permission to remove the escort chain, but a senior manager refused and the restraints remained in place for another three hours.

78. The senior manager told the investigator that she did not remember being told that a hospital doctor considered the use of restraints placed the escorting officers at unnecessary risk. We note that the escorting officer did not make the request directly to her but that it was made via a Custodial Manager. It is therefore possible that she was not given this information. However, we would have expected her to consider whether the use of restraints was justified at all given Mr Lee-Channing's state of health at this point. We are concerned that the delay in authorising the escorting officers to remove the escort chain increased their risk of exposure to COVID-19.

79. We are also concerned that, at interview, the senior manager did not appear to understand the legal position on the use of restraints.

80. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

The Governor should ensure that:

- **a senior manager is informed whenever a healthcare professional requests the removal of restraints; and**
- **the reasons are recorded if the request is not agreed.**

The Governor should ensure that all staff who act as Duty Governor have received the necessary training to perform the role.

Liaison with Mr Lee-Channing's family

81. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the processes that should be followed when a prisoner suffers a rapid deterioration in their physical health and when they die. This includes that prisons must have procedures to promptly engage with the prisoner's next of kin.

82. HMPPS guidance, *Acting as Family Liaison Officer by telephone – communicating with a prisoner's next of kin*, published in March 2020, sets out the processes for family liaison during the COVID-19 pandemic. It says that prisoners' families should continue to be told if a prisoner becomes seriously ill, but that, due to social distancing rules, this should be done by telephone.

83. When Mr Lee-Channing was taken to hospital on 7 April, hospital doctors promptly admitted him to the resus unit. Despite the rapid deterioration in his condition, the prison did not appoint a family liaison officer until 8 April and there is no record that she contacted Mr Lee-Channing's partner until 9.30am on 9 April, an hour before he died. While Mr Lee-Channing's partner had received some information from the hospital before this, we are concerned that no one from the prison contacted her before 9 April. We are also concerned that the FLO did not record details of her breaking the news of Mr Lee-Channing's death with his partner in the family liaison log. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011, that:

- **staff notify a prisoner's next of kin as soon as possible when they become seriously ill; and**
- **every contact with the next of kin is recorded in the family liaison log.**

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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
F I 020 7633 4141