Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Kwan, a prisoner at HMP Channings Wood, on 8 July 2023

A report by the Prisons and Probation Ombudsman

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

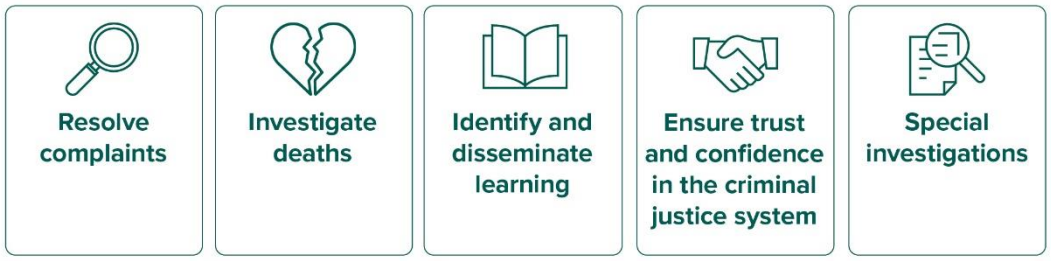
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Kwan died of metastatic pancreatic cancer (cancer of the pancreas that has spread to other parts of his body) on 8 July 2023, at Rowcroft Hospice, while a prisoner at HMP Channings Wood. He was 62 years old. We offer our condolences to his family and friends.

4. The PPO family liaison officer wrote to Mr Kwan's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

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

6. NHS England commissioned an independent clinical reviewer, to review Mr Kwan's clinical care at HMP Channings Wood.

7. The clinical reviewer concluded that, in most aspects, the clinical care Mr Kwan received at HMP Channings Wood was of a good standard and equivalent to that which he could have expected to receive in the community. She made four recommendations, one of which was not directly relevant to Mr Kwan's death and is not included in this report but which the Head of Healthcare will wish to address.

Good practice

Transfer to hospice and multidisciplinary working

8. There was good multidisciplinary working between hospital staff, the hospice staff, prison healthcare staff and prison staff which ensured that a hospice bed was secured promptly for Mr Kwan.

9. Mr Kwan praised the quality of family liaison he received while he was unwell.

Recommendations from clinical review

- The Head of Healthcare should ensure that there is a robust process in place for the review of healthcare applications to ensure a timely review by the most appropriate member of the healthcare team.

- The GP provider should review the prison GP wait times to ensure all is being done to bring it in line with community access to GPs.

- The GP provider should ensure that all GPs are using the GMCs guidance on record keeping including when using remote consultation methods.

Inquest

10. The inquest into Mr Kwan's death concluded on 7 August 2025 and found that Mr Kwan died of natural causes.

Adrian Usher **January 2024**
Prisons and Probation Ombudsman

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