

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Bowkett a prisoner at HMP Hewell on 8 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Daniel Bowkett died at hospital, on 8 June 2016, of a heart attack after taking a drug overdose. He was 31 years old. I offer my condolences to Mr Bowkett's family and friends.

While the prison has made attempts to reduce the supply of and demand for illicit drugs, I believe that Mr Bowkett's death demonstrates that more needs to be done to address this issue. This view is reinforced by the findings of the last inspection by HM Inspectorate of Prisons.

When Mr Bowkett collapsed in his cell at HMP Hewell, there was a general lack of awareness of the prison's protocol for dealing with a medical emergency. I agree with the clinical reviewer's conclusion that the delay in commencing cardiopulmonary resuscitation and calling for an ambulance was not equivalent to what would be expected in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2017

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 5
Findings 8
Findings 8

Summary

Events

1. On 28 December 2015, Mr Daniel Bowkett was sentenced to 30 weeks in prison for a violent offence and theft. He was sent to HMP Bristol, before being moved to HMP Guys Marsh on 5 January 2016 and HMP Hewell on 9 March.
2. Mr Bowkett had a long history of alcohol and substance misuse. He denied recent drug use and received help from the substance misuse service.
3. On arrival into prison, prison GPs prescribed Mr Bowkett a reducing programme of methadone. He started on a 50mls dosage, which prison GPs reduced to 45mls on 24 March and to 40mls on 13 April.
4. At approximately 6.25am on 8 June, an officer found Mr Bowkett collapsed on the floor of his cell. The officer asked for a nurse to attend but did not use an emergency code. The nurse arrived approximately ten minutes later. When she arrived at the cell, she organised the resuscitation attempt and asked for an ambulance to be called.
5. An ambulance crew arrived at Mr Bowkett's cell at 6.55am. Paramedics took Mr Bowkett to hospital but he did not regain consciousness and died at 7.55am on 8 June.

Findings

6. Staff at Hewell worked cooperatively to help Mr Bowkett address his substance misuse problems. Healthcare staff referred him to the substance misuse service and ensured he took his prescribed medication. We are satisfied that healthcare staff provided Mr Bowkett with an appropriate level of substance misuse support.
7. The post-mortem and toxicology examination revealed Mr Bowkett died from a heart attack, caused by ingesting heroin and methadone. We conclude he obtained drugs illicitly in prison, which taken alongside his prescribed methadone dose proved lethal.
8. To limit the supply of drugs, the prison said they use dogs to detect drugs, pass on information about the dangers of drugs to prisoners and use multidisciplinary meetings to obtain better intelligence on those prisoners suspected of using and trading drugs. While we acknowledge the prison's attempts to limit the supply of drugs, we believe that Mr Bowkett's death shows that further work is required.
9. Although Mr Bowkett's sudden death would have been difficult to predict, the clinical reviewer concluded that the delay in commencing cardiopulmonary resuscitation and calling for an ambulance was not equivalent to what would be expected in the community. We were also concerned that prison staff could not easily access simple life saving equipment, including a defibrillator.

Recommendations

- The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.
- The Governor should ensure that all staff can access defibrillators.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling, directing or discharging ambulances.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Bowkett's prison and medical records.
12. Another investigator interviewed one prisoner at HMP Hewell on 9 June 2016. The investigator interviewed four members of staff at Hewell on 28 June. She conducted telephone interviews with two members of staff on 30 June and 12 September.
13. NHS England commissioned a clinical reviewer to review Mr Bowkett's clinical care at the prison. She conducted joint interviews with the investigator on 28 June.
14. We informed HM Coroner for Worcestershire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Bowkett's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for the investigation to consider what happened and if there was a delay with the ambulance getting to him.
16. Mr Bowkett's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hewell

18. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Bowkett was at the Blakenhurst site, which comprises six houseblocks, holding around 1100 men. Care UK provide health services.

HM Inspectorate of Prisons

19. The report of the most recent inspection of HMP Hewell has not yet been published. At the time of the previous inspection in July 2014, inspectors found that all new arrivals were assessed for physical and mental health needs and any substance misuse issues. There was a good range of primary care and screening services but delivery of some health services had been affected by staff shortages. Inpatient care was satisfactory but the environment was not sufficiently therapeutic. Prisoners were positive about the care they received from the integrated substance misuse service and said they had received good support for drug and alcohol problems. Inspectors found that illicit drugs and medication were easily available and measures needed to be improved to reduce this. They said there should be a consistent drug testing regime and the security team should develop stronger links with other key departments.

Independent Monitoring Board

20. 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 November 2014, the IMB recognised that healthcare managers had worked hard to improve the efficiency of health services but the IMB was concerned about the number of unfilled vacancies for nurses. The IMB noted that there had been continued upgrades to the healthcare inpatient unit. They said there had been an improvement regarding medication management to try to reduce the illegal use of prescribed medication. They said that random drug tests should be conducted at weekends.

Previous deaths at HMP Hewell

21. Mr Bowkett was the sixth prisoner at Hewell to die since January 2015. There were no significant similarities with the circumstances of the previous deaths.

Key Events

22. On 28 December 2015, Mr Daniel Bowkett was sentenced to 30 weeks in prison for a violent offence and theft, and was sent initially to HMP Bristol. On 5 January 2016, Mr Bowkett was moved to HMP Guys Marsh and six days later, he was also charged with criminal damage. Mr Bowkett had a long history of alcohol and drug abuse, which healthcare staff treated with a daily dose of methadone.
23. On 9 March, Mr Bowkett was moved to HMP Hewell. When he arrived at Hewell, a nurse assessed him and noted he was prescribed 50mls of methadone daily. He referred Mr Bowkett to the integrated substance misuse service and explained that he would need to collect his medication each day. He noted Mr Bowkett had quite high blood pressure (123/94), was overweight (he had a body mass index of 31.22) and was a smoker. Mr Bowkett accepted smoking cessation.
24. Healthcare staff saw Mr Bowkett daily as part of his methadone reduction programme.
25. On 10 March, a worker from the substance misuse team discussed Mr Bowkett's alcohol and drug detoxification plan with him. Mr Bowkett told him that he had been switching between alcohol and drugs for several years. Mr Bowkett declined to join the substance misuse or alcoholic anonymous support groups. The worker talked to him about mental health support and how to access support to maintain a drug and alcohol free lifestyle. The worker also said that Hewell generally prescribed a maximum methadone dose of 40mls.
26. From 24 March, a nursing Sister reduced his methadone prescription to 45mls.
27. On 30 March, the worker from the substance misuse team reviewed the progress of Mr Bowkett's drug detoxification. Mr Bowkett said he felt fine, though he did not know that his methadone dose had reduced from 50mls to 45mls. The worker told Mr Bowkett that his methadone dose would reduce again to 40mls, which Mr Bowkett said he wanted to remain on until he was released from prison. The following day, his methadone dose was reduced to 40mls.
28. On 5 April, Mr Bowkett asked the worker from the substance misuse team to complete a gym application for him, as he wanted to improve his physical wellbeing. The application was completed.
29. On 13 April, Mr Bowkett told the worker from the misuse team that he was on 40mls of methadone and had remained illicit drug free at Hewell.
30. The worker from the substance misuse team saw Mr Bowkett on 17 May. Mr Bowkett told him that he was feeling the benefits of the gym sessions and felt well. Mr Bowkett told him he faced further charges so was unsure about the future but his goal was to remain illicit drug free.
31. The worker from the substance misuse team last saw Mr Bowkett on 6 June. Mr Bowkett told him he would be released in four days. He reminded Mr Bowkett of the overdose risks outside of prison and told him about a release appointment.

Events on 8 June 2016

32. Mr Bowkett's cellmate said that they had shared a double cell for approximately one month. Mr Bowkett slept on the top bunk.
33. At approximately 4.45am, an operational support grade (OSG) worker completed a welfare check and saw Mr Bowkett and his cellmate sleeping in their bunks.
34. At approximately 6.25am, the OSG returned to the cell to wake Mr Bowkett as he had a court appearance that day. He saw Mr Bowkett face down on the floor. At the same time, Mr Bowkett's cellmate woke and he saw Mr Bowkett face down on the floor. He got out of bed and checked Mr Bowkett but he was not breathing and had no pulse. He said Mr Bowkett was warm, his face was clammy and his lips blue.
35. The OSG said he watched this from outside cell. He used his radio to ask for a nurse, the night manager and an officer to come to the cell so they could go in and check Mr Bowkett. He said he did not use an emergency code, as he did not think it was warranted.
36. At approximately 6.30am, the night duty manager heard the OSG's radio call for medical assistance. He told officers to collect the nurse and go to Mr Bowkett's cell. The manager said he did not ask for an ambulance, as he wanted to assess the situation when he arrived at the cell.
37. At approximately 6.35am, after hearing the radio call, a nurse collected four emergency bags to take to Mr Bowkett's cell, as she had no information about the nature of the emergency. An officer met her on route and helped her carry the bags. On arrival, the nurse said two officers were outside the cell. They unlocked the door and went in.
38. The nurse said she checked for a pulse but could not find one. She told an officer that an ambulance was needed and the officer contacted the control room. Prison records show that the control room called for an ambulance at 6.37am though the Ambulance Service noted that they received the call at 6.41am. She said officers helped her turn Mr Bowkett onto his back and she noted that there was residue and saliva around his mouth. She also noted that his face was pink. Together with the officers, she started cardiopulmonary resuscitation (CPR). One of the emergency bags contained a defibrillator, which she attached to Mr Bowkett. The reading from the defibrillator said no shockable rhythm was advised, so they continued with CPR until the ambulance crew arrived at the cell.
39. Two ambulances arrived at 6.49am and 6.53am. Paramedics were with Mr Bowkett at 6.55am and took Mr Bowkett to hospital at 7.29am. Two officers escorted Mr Bowkett but they did not restrain him.
40. At hospital, Mr Bowkett's condition continued to decline and he died at 7.55am.

Contact with Mr Bowkett's family

41. On 8 June, the prison appointed an officer as the family liaison officer. Mr Bowkett had listed his mother as his next of kin. As she lived some distance from Hewell, the officer asked for staff at HMP Cardiff to visit her to break the news to her. However, when staff from Cardiff visited her address, there was no answer. There was no information about contact details for Mr Bowkett's father in his record.
42. The officer then found contact details for Mr Bowkett's partner. When she and a prison manager were arranging to visit Mr Bowkett's partner, she rang the prison and the news was broken to her. They visited Mr Bowkett's partner and she told them she would try to get the contact details for Mr Bowkett's mother. The police located Mr Bowkett's father and broke the news to him.
43. Mr Bowkett's mother contacted the prison at 7.55am on 9 June and the news was broken to her. The officer offered advice and support. She remained in contact with her until after Mr Bowkett's funeral. Mr Bowkett's funeral was held on 24 June and the prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

44. After Mr Bowkett's death, the duty manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
45. The prison posted notices informing staff and prisoners of Mr Bowkett's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Bowkett's death. Mr Bowkett's cellmate moved to another cell and the duty manager offered support.

Post-mortem report

46. A post mortem examination concluded that Mr Bowkett died of acute cardio respiratory failure (a heart attack) and heroin and methadone ingestion. A toxicology screening detected heroin and methadone.

Findings

Clinical care

47. The clinical reviewer noted that Mr Bowkett had a long history of alcoholism and substance misuse. When Mr Bowkett arrived at Hewell, a nurse properly assessed him. Healthcare staff appropriately prescribed methadone and he appeared to comply with his detoxification programme.
48. We agree with the clinical reviewer that the substance misuse consultations were of a good standard and were well documented. The clinical reviewer concluded that Mr Bowkett positively engaged with the substance misuse service and there was no reason for the substance misuse workers to suspect that Mr Bowkett was using illicit drugs. Additionally, while Mr Bowkett was in Hewell, the prison had not received any intelligence that he was misusing drugs and he had not been selected for a mandatory drug test. Therefore, we consider that it was not possible to foresee his sudden death from drug toxicity.

Illicit drugs

49. Mr Bowkett's cellmate told the investigator that he did not think Mr Bowkett had used any illicit substances in prison. However, the presence of heroin in Mr Bowkett system suggests that his misuse of drugs continued in prison.
50. The prison's security manager said that drugs had been smuggled into the prison and he outlined a number of initiatives to disrupt them, which included using dogs to detect drugs, passing on information about the dangers of drugs to prisoners and using multidisciplinary meetings to obtain better intelligence on those prisoners suspected of using and trading drugs. While we recognise that the prison has attempted to disrupt the supply of drugs, the death of Mr Bowkett demonstrates that these attempts have not been successful. We agree with HMIP that more needs to be done to disrupt the supply and demand for illicit drugs. We make the following recommendation:

The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.

Emergency response

51. After the OSG found Mr Bowkett unresponsive on the floor of his cell, it took 11 minutes for a nurse to arrive and for cardiopulmonary resuscitation (CPR) to start. The clinical reviewer said that recent CPR guidance states that every minute that passes, from the stopping of the heart, increases the risk of death by 7-10%. We understand that a programme of CPR training is underway at Hewell so more staff will be able to commence CPR if necessary.
52. The clinical reviewer also said that as the defibrillators were locked away on the houseblocks, where only healthcare staff could access them, there was no system for prison staff to be able to access a defibrillator independently if required and therefore no back up system to assist healthcare staff if there was a machine failure.

53. It became apparent during the investigation that prison staff did not clearly understand the use of emergency codes. An ambulance was not called until the nurse arrived at the cell and said one was needed. As a result, it took 30 minutes for an ambulance crew to reach Mr Bowkett after he was found.
54. Prison Service Instruction (PSI) 03/2013, medical emergency response codes, gives clear guidance on the use of emergency codes and that a code blue emergency code (which indicates that a prisoner is unconscious or not breathing) should prompt the immediate request of an emergency ambulance. Hewell issued a local instruction in line with the PSI on 27 April 2015. The local instruction says for non medical emergencies a radio call for healthcare staff is appropriate but for emergencies, a code must be used. The instruction also says that if there is any doubt about the nature of the injury, an ambulance must be called, as it is better to act with caution and request an ambulance that can be cancelled if it is not required.
55. We agree with the clinical reviewer that the delays in starting CPR or calling an ambulance gave Mr Bowkett very little chance of survival and that this was not equivalent to what would be expected in the community. We make the following recommendations:
- **The Governor should ensure that all staff can access defibrillators.**
 - **The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and ensures there are no delays in calling, directing or discharging ambulances.**

**Prisons &
Probation**

Ombudsman
Independent Investigations