

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Bowman, a prisoner at HMP Lindholme, on 29 April 2020

**A report by the Prisons and Probation Ombudsman**

## 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*



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## Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Robert Bowman died of carcinomatosis (a condition in which multiple cancers develop at the same time) on 29 April 2020 at HMP Lindholme. This was caused by cancer of the sigmoid colon (part of the large intestine). He also had ischaemic heart disease as a result of coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart) which contributed to but did not cause his death. He was 74 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that Lindholme provided Mr Bowman with care that was both responsive and equivalent to that which he could have expected to receive in the community.
5. We did not identify any non-clinical issues of concern and we make no recommendations.

### Investigation Process

6. NHS England commissioned an independent to review Mr Bowman's clinical care at HMP Lindholme. The clinical review is attached to this report at Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Bowman's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Bowman's next of kin to explain the investigation. He did not respond.
9. We shared the initial report with the prison service. There were no factual inaccuracies.
10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

### Previous deaths at Lindholme

11. There were two deaths from natural causes, three drug-related deaths and three self-inflicted deaths at HMP Lindholme in the two years before Mr Bowman's death. There are no significant similarities between our findings in the investigation of Mr Bowman's death and the findings in our investigation of these previous deaths.

## Key Events

12. On 7 April 2006, Mr Robert Bowman was sentenced to a minimum of two years in prison for threats to kill. (This was an indeterminate sentence for public protection.) Mr Bowman refused to engage in sentence planning and refused to attend parole meetings. On 4 October 2008, Mr Bowman was transferred to HMP Lindholme.
13. On 12 September 2017, a nurse saw Mr Bowman and told him that the bowel cancer screen that he had taken showed a positive result and that he needed to have a colonoscopy (a fibre-optic examination of the large intestine) to see if he had cancer.
14. On 18 February 2018, Mr Bowman went to hospital for the colonoscopy which indicated possible bowel cancer.
15. On 9 July, a prison GP and a nurse told Mr Bowman that a CT scan showed that he had bowel cancer which had spread to other parts of his body, and that treatment to cure the cancer was not likely.
16. On 31 July, a consultant colorectal surgeon and a nurse saw Mr Bowman in hospital. He told Mr Bowman that he would not be able to have surgery because the cancer had spread, and that the best course of treatment was chemotherapy.
17. After Mr Bowman saw a consultant clinical oncologist on 11 January 2019, he had three cycles of chemotherapy.
18. On 29 April 2020, Mr Bowman died of carcinomatosis (multiple cancers), which had spread from the sigmoid colon. He also had heart disease which contributed to but did not cause his death.

