

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ronald Rowe, a prisoner at HMP Hewell, on 6 June 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 Ronald Rowe died on 6 June 2020, from an upper gastrointestinal bleed (secondary to his end stage liver disease) while a prisoner at HMP Hewell. Mr Rowe was 68 years old. I offer my condolences to Mr Rowe's family and friends.
4. Mr Rowe had a history of alcohol dependency, and in May 2018 he was diagnosed with cirrhosis of the liver and colon cancer. In October, he was diagnosed with oesophageal varices, a common complication of liver disease. (Varices are abnormal, enlarged veins in the oesophagus, the tube that connects the throat and stomach.) In September 2019, Mr Rowe was told that his cancer had spread to his liver.
5. The clinical reviewer concluded that the clinical care Mr Rowe received for his liver disease at HMP Hewell was of a good standard and equivalent to that he could have expected to receive in the community. She was concerned about care planning, in particular that the plan to manage Mr Rowe's colon cancer was put in place too late. She made two recommendations that do not directly relate to the circumstances of Mr Rowe's death.
6. We found no non-clinical issues of concern.
7. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Rowe's clinical care at HMP Hewell. The clinical reviewer's report is attached as Annex 1.
9. The PPO investigator has investigated non-clinical issues, including Mr Rowe's location, the security arrangements for his hospital escorts, liaison with his next of kin and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Rowe's friend, his nominated next of kin, to explain the investigation. She did not have any specific questions for us to consider.
11. A solicitor representing Mr Rowe's wife contacted the PPO family liaison officer on 14 August 2020 asking a number of questions relating to his health, treatment and his management while he was on licence. Questions relating to Mr Rowe's

healthcare are covered in the clinical review. We have written to Mr Rowe's wife to explain that some matters fall outside the remit of this investigation.

12. Mr Rowe's daughter contacted our office on 5 October asking questions relating to her father's health and management while on licence and spoke to the investigator on 7 October to discuss this. Mr Rowe's nominated next of kin, his wife and daughter will receive a copy of this report.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
14. Mr Rowe's wife received a copy of the initial report. Mrs Rowe pointed out one factual inaccuracy. This report has been amended accordingly. Mrs Rowe also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

### **Previous deaths at HMP Hewell**

15. Mr Rowe was the 10<sup>th</sup> prisoner to die at HMP Hewell since June 2018. Of these deaths, five were from natural causes and five were self-inflicted or drug-related deaths. There are no similarities between our findings in the investigation into Mr Rowe's death and our investigation findings for the previous deaths.

## Key Events

16. On 4 September 2019, Mr Ronald Rowe was sentenced to twelve months imprisonment for assault, actual bodily harm and criminal damage. He was sent to HMP Birmingham.
17. Mr Rowe had a history of alcohol dependency and was diagnosed with cirrhosis of the liver and colon cancer in May 2018, before he came to prison. The following October, Mr Rowe was diagnosed with oesophageal varices, a common complication of liver disease. In September 2019, Mr Rowe was told that his cancer had spread to his liver.
18. On 16 January 2020, Mr Rowe was released from prison on licence. He was recalled to prison on 27 March for breaching a restraining order and was taken to HMP Hewell.
19. On 6 April, Mr Rowe was diagnosed with ascites (a build-up of fluid in the abdomen) caused by liver disease and, on 19 May, went to Alexandra Hospital for treatment of this condition. He was restrained by 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). A prison risk assessment found Mr Rowe to be a medium risk to the public. Healthcare staff contributed information about his medical condition to inform the assessment of his risk. On 21 May, he transferred to Worcester Royal Hospital for further review.
20. On 21 May, Mr Rowe's offender supervisor started an application for early release on compassionate grounds. The application was sent to the prison's healthcare department for completion. On 26 May, a hospital nurse recorded that Mr Rowe did not need palliative care and his condition could eventually be managed in prison. In light of this, Mr Rowe's application for early release was not pursued.
21. On 3 June, Mr Rowe was discharged to Hewell after a hospital review and was admitted to the prison's inpatient unit. On 4 June, Mr Rowe told the prison GP that if his condition deteriorated, he did not want to be resuscitated and signed an order to that effect.
22. At 5.54am on 6 June, a nurse checked Mr Rowe in his cell and recorded that he was asleep and breathing. The nurse returned to his cell at 6.36am and found Mr Rowe lying on the floor unresponsive, by his toilet. He had no pulse or signs of life. The nurse could see blood underneath his body and to the side of his mouth, and alerted an officer, who immediately called a code blue, an emergency response code. The code blue was later stood down as Mr Rowe had a do not resuscitate order in place. Mr Rowe's death was confirmed at 6.39am.
23. Mr Rowe died of acute gastric bleeding secondary to his severe liver disease. The clinical reviewer noted that a person with this condition can die of acute blood loss within a few minutes.
24. The clinical reviewer concluded that the clinical care Mr Rowe received for his liver disease at HMP Hewell was of a good standard and was equivalent to that he could have expected to receive in the community. While patients with

cirrhosis should be offered an endoscopy in line with NICE guidelines, the clinical reviewer concluded that there was no indication that Mr Rowe was in need of an emergency endoscopy for his varices, and there were no routine endoscopies being scheduled due to COVID-19. She made two recommendations.

25. The Coroner accepted the cause of death provided by the prison doctor and no post-mortem examination was carried out. The doctor gave Mr Rowe's cause of death as, 1a Upper gastrointestinal bleed; 1b End stage alcoholic liver disease.

**Karen Johnson**  
**Assistant Ombudsman**

**December 2020**

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