Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charles Dowell, also known as Mr Chegory McCarty, a prisoner at HMP Bullingdon, on 25 May 2020

A report by the Prisons and Probation Ombudsman

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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 Charles Dowell, also known as Mr Chegory McCarty, was found dead in his cell at HMP Bullingdon on 25 May 2020. The cause of his death is unascertained. He was 35 years old. Post-mortem toxicology tests showed that Mr Dowell had used cannabis, a psychoactive substance (PS) and prison-brewed alcohol (hooch) before he died. I offer my condolences to his family and friends.

Mr Dowell was frustrated that he had been held on remand for nearly a year. However, there is no evidence that Mr Dowell intended to take his life at the time.

It is extremely troubling that Mr Dowell was able to access and use illicit substances, including PS, with apparent ease at Bullingdon, particularly as he was a trusted prisoner with a responsible cleaning job. HM Inspectorate of Prisons highlighted this as an issue when they last inspected Bullingdon in July 2019. While the prison has taken some steps to reduce drug supply, work to update its drugs strategy has stalled because of the COVID-19 pandemic. This work needs to be revived and properly addressed.

We are also concerned that there were procedural failings during the roll check and at unlock and that staff did not respond quickly enough when they found Mr Dowell unresponsive in his cell. While we do not know whether the delay in finding Mr Dowell affected the outcome for him, it is critical that prison staff carry out full roll and welfare checks as early intervention can save lives.

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 **October 2021**

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Summary

Events

1. On 8 July 2019, Mr Charles Dowell, also known as Mr Chegory McCarty, was remanded to HMP Bullingdon. He was a foreign national and this was his first time in prison. Mr Dowell had no significant physical or mental health concerns.

2. Mr Dowell's court hearing was postponed in March 2020 due to the COVID-19 pandemic. Mr Dowell was frustrated about this and staff monitored him under suicide and self-harm prevention procedures (known as ACCT) from 18 to 26 March because of his low mood.

3. Mr Dowell's cellmate said that on the evening of 24 May, Mr Dowell drank most of a two-litre bottle of illicit alcohol (hooch) but said that he had not been concerned about him.

4. On the morning of 25 May, staff went to Mr Dowell's cell on at least three occasions and, like Mr Dowell's cellmate, believed that he was asleep. At 12.35pm, a member of staff arrived at Mr Dowell's cell to collect him for work. Mr Dowell was still in bed and was unresponsive. The officer radioed a medical emergency code, and an ambulance was called. Mr Dowell showed no signs of life and rigor mortis was present. At 12.45pm, paramedics confirmed that Mr Dowell had died.

5. The post-mortem was unable to determine the cause of Mr Dowell's death and, while psychoactive substances (PS), cannabis and alcohol were found in his system, the pathologist could not ascertain if any of these substances contributed to or caused his death.

Findings

Roll checks

6. Staff failed to conduct the evening roll check on the evening of 24 May and did not check on Mr Dowell's wellbeing.

Unlock procedure

7. When staff unlocked Mr Dowell's cell on the morning of 25 May, they should have checked him physically and tried to obtain a positive response from him. They did not do so and, as a result, Mr Dowell was not discovered until 12.35pm, over four hours after his cell had been unlocked that morning. We cannot say whether the outcome might have been different for Mr Dowell if the correct procedures had been followed and he had been found unresponsive earlier.

Emergency response

8. When staff found Mr Dowell unresponsive in his cell, there was a delay of about three minutes before an emergency medical code was called. This delay did not affect the outcome for Mr Dowell as he had been dead for some time when he was found, but it could make a significant difference in other cases.

Drug strategy

9. Although Bullingdon has taken some steps to address its drug supply issues, Mr Dowell's death is a stark reminder that more needs to be done to reduce the availability and detection of drugs and alcohol. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority.

Liaison with Mr Dowell's next of kin

10. Following Mr Dowell's death, the prison failed to keep in contact with his family in a timely manner or to appoint a deputy family liaison officer.

Clinical care

11. The clinical reviewer found that, overall, the care that Mr Dowell received at Bullingdon was equivalent to that which he could have expected to receive in the community.

12. We share the clinical reviewer's view that there is a need for a framework to enable prison healthcare staff to recognise and confirm a prisoner's death so that they do not need to request an ambulance just for the purposes of confirming the death.

Recommendations

- The Governor should ensure that staff understand their responsibilities when completing roll checks and that roll checks are properly carried out in line with local procedures.
- The Governor should ensure that when cell doors are unlocked, staff satisfy themselves that prisoners are safe and that there are no immediate issues that need attention.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code.
- The Governor should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.
- Practice Plus Group Health and Rehabilitation Services Limited and the Head of Healthcare at Bullingdon should:
    - review the role of paramedics working within the prison in relation to undertaking recognition of life extinct (ROLE). If appropriate, this should include the provision of local operating procedures and supporting paperwork and ensure all staff are aware;
    - and update the Ombudsman within six months on progress made.

The Investigation Process

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

14. The investigator obtained copies of relevant extracts from Mr Dowell's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Dowell's clinical care at the prison. The investigator interviewed eight prison staff. Some interviews were conducted jointly with the clinical reviewer. The interviews were completed by video conference because of the restrictions imposed due to the COVID-19 pandemic.

16. We informed HM Coroner for Oxfordshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. We contacted Mr Dowell's partner to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Dowell's partner, and the solicitor representing her, wanted to know all the events that led to his death, including:

    - whether he might have had an allergic reaction to a Hepatitis B vaccination he had about two weeks before his death;
    - whether he had contracted COVID-19 after cleaning the cell of a prisoner diagnosed with the virus; and
    - why he was not discovered earlier on the day he died?

    These questions have been addressed in this report and in the clinical review.

18. Mr Dowell's family received a copy of the draft 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.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified a factual inaccuracy in the report which has been amended and the report updated accordingly. All recommendations were accepted.

Background Information

HMP Bullingdon

20. HMP Bullingdon is a local, resettlement prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Care UK (which changed its name to Practice Plus Group on 1 October 2020) provides healthcare services and Cotswold Medicare Ltd provides GP services at the prison. There is an inpatient healthcare unit, with 24-hour nursing care.

HM Inspectorate of Prisons

21. The most recent inspection of Bullingdon was in July 2019. Inspectors found that healthcare had improved since their previous inspection in May 2017, and that it was now generally a very good service.

22. Inspectors reported that even though there were indications that illicit drugs were becoming harder to obtain, more than half of the prisoners believed they remained easily accessible, and around one in five said that they had acquired a drug habit since arriving at Bullingdon. Inspectors said that an overarching drug supply reduction strategy and more suspicion testing were needed.

23. Inspectors noted that the prison efficiently collated and analysed a substantial amount of intelligence across the prison. The security department held weekly meetings, where appropriate actions were set out in response to this intelligence. However, too many of those actions, mostly intelligence-led searches and suspicion drug tests, were not completed because staff were not available.

Independent Monitoring Board

24. 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 30 June 2020, the IMB reported that the availability of drugs was still a serious problem but one which unsurprisingly had decreased with the considerable restrictions on prisoner movement and visits because of COVID-19. Despite this, the report noted that during May and early June 2020, the availability of drugs had rapidly increased.

Previous deaths at HMP Bullingdon

25. Mr Dowell was the ninth prisoner to die at Bullingdon since May 2018. Of the previous deaths, six were from natural causes and two were self-inflicted.

26. There was a drug-related death in July 2020 of a prisoner who worked as a cleaner on Mr Dowell's unit.

Key Events

27. On 8 July 2019, Mr Charles Dowell, also known as Mr Chegory McCarty, was charged with grievous bodily harm. Although he denied it, the Home Office considered that he was a foreign national who was an overstayer in the UK.

28. He was remanded to HMP Bullingdon on 5 August 2019. It was Mr Dowell's first time in prison. His person escort record (PER) noted that he had mental health issues. A prison officer identified this during Mr Dowell's reception interview.

29. At Mr Dowell's initial health screen, he said he was 'okay', had no medical issues, no thoughts of suicide or self-harm and was not taking any medication. A nurse noted that Mr Dowell had no previous psychiatric history and had no concerns about his mental health. She completed an alcohol assessment, which indicated that Mr Dowell was at an increased or higher risk of drinking. She referred him to the substance misuse team for brief alcohol intervention support, but Mr Dowell declined this, as well as the offer of smoking cessation treatment. While there was no evidence that Mr Dowell misused illicit substances, he refused to say whether he had a history of substance misuse.

30. The next day, 9 July, a nurse completed Mr Dowell's secondary health screen and had no concerns about him. Mr Dowell again declined support from the substance misuse team and said that he did not use drugs. He later moved to A Wing.

31. On 15 July, Mr Dowell's medical record noted that he had asked for medication to help him sleep. He was prescribed a short course of promethazine.

32. On 24 July, a nurse saw Mr Dowell after he complained of having chest pain. Mr Dowell said that he had been exercising in his cell. He was examined and given advice about what to do if the pain worsened.

33. On the morning of 24 September, another prisoner assaulted Mr Dowell. A nurse examined him and noted that he had no serious injuries.

34. As a result of the assault, staff moved Mr Dowell to D Wing. Soon afterwards, Mr Dowell punched another prisoner during the movement of prisoners between wings. He said that this was in retaliation for being assaulted earlier that day. Staff issued a warning.

35. On 24 November, Home Office immigration staff visited Mr Dowell. They gave him immigration paperwork as they considered him an overstayer in the UK. They gave him the opportunity to make representations about this. The documentation noted that Mr Dowell's real name was Chegory Paul McCarty, an Antiguan and Barbadian national who had arrived in the UK in 2009. The Home Office recognised Mr Dowell as a foreign national offender who was liable for enforcement action. Mr Dowell was adamant that he was a British citizen and refused to sign the paperwork. Prison records noted that Mr Dowell's case was to be referred to the Home Office's Criminal Casework Directorate to assess whether he met the criteria for automatic deportation if he was convicted.

36. From 25 November to early December, Mr Dowell attended court on a number of occasions. On each occasion, healthcare staff completed welfare checks and noted no concerns.

37. On 18 December, staff placed Mr Dowell and his cellmate on a disciplinary charge after they found a quantity of fermenting liquid (hooch) in a five-litre container in their cell. Following a disciplinary hearing the next day, Mr Dowell's Incentives and Earned Privileges (IEP) regime level was reduced to basic (which meant that he lost privileges such as time out of his cell).

38. On 21 December, staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Dowell threatened to climb onto the bars and hang himself because he had been placed on basic IEP level. He said he felt suicidal, that the system was racist and that he was being treated unfairly. Staff set ACCT observations levels at hourly intervals and noted that he had no history of self-harm.

39. A supervising officer held an ACCT review the next day, and a mental health nurse attended. They identified six concerns for Mr Dowell. Mr Dowell was not happy to be on the basic IEP regime. He said he understood but felt stressed and had bad nightmares and poor sleep. The panel referred Mr Dowell to the mental health team. They noted that he had not been assigned a key worker or a job. Paperwork was completed to ensure he was allocated a key worker as soon as possible and he was placed on the activity waiting list. It was also agreed that Mr Dowell would complete an English course.

40. On 25 December, a supervising officer completed Mr Dowell's second ACCT review. Another supervising officer and two nurses from the mental health team attended. Mr Dowell complained that he remained on the basic regime and still had no job, although he had passed English and Maths in a prison class. The panel noted that an officer had been allocated as his key worker and would be able to help Mr Dowell get a job. Appointments were also made for Mr Dowell to see the prison GP and the dentist. It was decided that ACCT monitoring should continue, and observations remained hourly.

41. On 2 January 2020, a Supervising Officer (SO) completed an ACCT review. A nurse attended. Mr Dowell said he had no thoughts of suicide or self-harm. The panel noted that Mr Dowell was very vocal during the review and did not appear to show signs of depression. He remained dissatisfied and said that he had been treated unfairly because of his race. He said he wanted to work in prison but was not happy that he had been told he would first need to complete an English course. During the review, he asked what the point of living was and felt that ACCT monitoring offered him no benefits, particularly as he disliked being checked every hour. The panel told Mr Dowell that he had upcoming appointments with the GP appointment (on 7January) and the dietician (on 13 January). The SO said he would check the position about Mr Dowell getting a job. The panel noted his risk level as low and reduced his observations to four at night, with staff required to have two meaningful conversations with him each day.

42. On 4 January, a SO chaired an ACCT review. The key worker and a nurse attended. Mr Dowell said that the catalyst for him being monitored under ACCT procedures was being placed on the basic regime. However, he had no thoughts of self-harm. Mr Dowell said that he was happy with his key worker and this had improved how he felt. He was still waiting to see the dentist and wanted a job. While the SO promised to look into Mr Dowell's job situation, he told him that there were no jobs available on the wing. The panel agreed that Mr Dowell's risk was low and stopped ACCT monitoring.

43. On 6 January, Mr Dowell submitted an application, asking to be prescribed sleeping medication. The next day, he failed to attend his appointment with the GP to review this request.

44. The prison dietician saw Mr Dowell on 13 January. She discussed healthy food options.

45. On 15 January, Mr Dowell attended an appointment with a prison GP but left the room before the doctor saw him. Mr Dowell told staff that he could not "wait any longer".

46. That day, the key worker spoke to Mr Dowell and noted that Mr Dowell had a job and was happy, although his job was not on his wing. He told Mr Dowell that he could still apply for a wing-based job.

47. On 20 January, a nurse from the mental health team assessed Mr Dowell. He said he was eating well, had no thoughts of self-harm and had a good insight into his current situation. The nurse noted that Mr Dowell engaged well and displayed no abnormal, paranoid or delusional beliefs, hallucinations or illusions. Mr Dowell explained that it was his first time in prison and that he was still adjusting to the regime and had difficulty sleeping. He said that his son was his protective factor, and he would never take his own life. Mr Dowell said that he did not drink regularly but when he did, it was to excess. He denied using any illicit substances in prison. The nurse noted that Mr Dowell presented as a low risk to others and himself and would benefit from sleep medication. He referred Mr Dowell to the prison GP and discharged him from the mental health team's patient list.

48. That day, the key worker saw Mr Dowell for a key worker session. Mr Dowell wanted to apply for enhanced IEP status and the key worker helped him apply.

49. By the end of January, Mr Dowell got a job as an industrial cleaner. Staff reported that his mood and attitude had generally improved.

50. On 18 March, an officer started ACCT procedures after Mr Dowell threatened to kill himself. He said that he could not cope with the fact that his court hearing had been postponed because of the COVID-19 pandemic. His ACCT observations were initially set at hourly.

51. A SO chaired an ACCT review the next day. Another SO and a nurse attended. The panel noted that Mr Dowell had been on remand for nine months and did not know when his trial would be held. He had difficulties sleeping and concentrating and while he had thoughts of suicide, he said that he would not take his life because his partner and child were reasons to live. It was noted that Mr Dowell was happy with his cellmate and knew how to access support. Mr Dowell said that he would speak to the chaplaincy, wanted to speak to a counsellor and see the dentist. The panel noted that Mr Dowell's observation level could be reduced to four observations at night, with staff having two conversations with him during the day. The nurse noted in Mr Dowell's medical record that Mr Dowell had been prescribed promethazine and referred to the substance misuse team.

52. On 26 March, a SO chaired the next ACCT review. A nurse from the mental health team attended. They noted that Mr Dowell had no thoughts of suicide or self-harm. Mr Dowell said that he periodically felt low about not having a trial date. He

continued to attend work and agreed to tell staff if he needed support. The panel agreed to stop ACCT monitoring.

53. Over the next few days, Mr Dowell's cellmate was moved, and he became the sole occupier of his cell. On 29 March, staff tried to allocate a new cellmate, but Mr Dowell refused to let the prisoner in. Staff gave Mr Dowell a warning but moved the prisoner to another cell.

54. On 20 April, the key worker saw Mr Dowell for a key worker session. They discussed Mr Dowell's poor attitude to sharing a cell. Mr Dowell said he wanted to share a cell with a prisoner of the same ethnicity.

55. On 24 April, staff gave Mr Dowell a warning for fighting with another prisoner. A nurse checked on Mr Dowell, but no treatment was necessary.

56. At the key worker session on 28 April, the key worker reminded Mr Dowell that he was an enhanced prisoner and expected to behave well and not be involved in fights. He also reminded Mr Dowell that he could not dictate who he shared a cell with.

57. On 4 May, Mr Dowell submitted an application to request if he could be moved to C Wing, the drug recovery spur. A Custodial Manager (CM) reviewed Mr Dowell's prison records but refused his application because he had recently received negative entries for fighting and not following orders to share a cell. Mr Dowell was informed that he was not suitable for a move to C Wing at that time and would have to improve his attitude and behaviour before such a move was granted.

58. Soon afterwards, Mr Dowell was moved to a new cell on D Wing, which he shared with another prisoner.

59. On 13 May, Mr Dowell attended a court hearing by video conference and was remanded into custody again. A nurse completed a wellbeing check and noted that Mr Dowell was okay and had no thoughts of suicide or self-harm. Mr Dowell said he did not know his next court date and was waiting to hear from his solicitor. He was upset that the court had not sentenced him as, in his view, they had all the evidence they needed.

24 May

60. On Sunday 24 May, Mr Dowell made a few phone calls to family members.

61. At 6.32pm, CCTV footage shows that Mr Dowell returned to his cell for the evening and an officer locked his cell door. In his police statement, Mr Dowell's cellmate said their evening was normal, and that they watched television and talked about television programmes. Mr Dowell's cellmate said that he had not seen any significant changes in Mr Dowell's behaviour before he died.

62. CCTV footage at 8.55pm shows that an Operational Support Grade (OSG) conducted the night roll check of the wing. He checked that each cell door was locked but did not look through any of the cell door observation panels. He noted that all prisoners were 'okay' and locked in their cells. At interview, the OSG told us that he did not recall the detail of his actions that evening but thought that he had looked through Mr Dowell's observation panel.

63. The cellmate said that Mr Dowell drank hooch throughout the evening until around 11.00pm. The cellmate said that when he tasted the hooch, he thought it was off, so Mr Dowell had drunk most of the two-litre bottle. He said that Mr Dowell was stumbling around the cell, drunk.

Monday 25 May

64. CCTV footage shows that at 4.55am, the OSG completed a roll check, checked that the cell doors were locked and looked through the observation panel to check that all prisoners were in their cells. The OSG raised no concerns about Mr Dowell.

65. The cellmate said that when he woke up at around 5.00am, Mr Dowell was in bed lying on his front, his hands under his front and his blanket covered up to his shoulders.

66. At 7.30am, Officer A and other officers started work on D Wing. Shortly afterwards, CCTV footage shows that officers delivered breakfast packs to all prisoners in their cells. Staff are also required to conduct a welfare check on prisoners at this time.

67. Officer A arrived at Mr Dowell's cell at 8.02am, unlocked and opened his cell door. He placed the breakfast packs on the cupboard inside the cell while saying good morning to both prisoners. Mr Dowell's bed was on the right-hand side of the cell. He said that Mr Dowell was lying on his right side, facing the wall, with his bed sheets pulled up to his shoulders. He said that he did not see Mr Dowell's face. The cellmate was lying on his back. Neither prisoner responded. The officer assumed that both prisoners were asleep and told us that this was not unusual. The cellmate said that he was woken up by the officer entering the cell and was aware that Mr Dowell did not move or respond.

68. CCTV footage at 8.15am shows that Officer B arrived at Mr Dowell's cell. He did not fully enter the cell but opened the cell door enough to ask both prisoners if they wanted to use the shower. The cellmate declined, but Mr Dowell did not respond. The officer told us that he thought that Mr Dowell was sleeping as he was not due to attend work. He could not recall whether he looked at Mr Dowell in his bed.

69. At 9.21am, Officer B returned to Mr Dowell's cell to complete the daily accommodation fabric check. (This is a check that the cell and appliances are in working order, and that window bars are secure and not damaged.) The cellmate was still in bed, facing the wall, dozing. The officer said that he checked the windows, window bars and cell bell and asked the cellmate if anything in the cell was broken. The cellmate said everything was working. The officer then left the cell. During his brief time in the cell, he said he did not pay much attention to Mr Dowell and only spoke to the cellmate.

70. The cellmate told us that he woke up at around 10.00am and watched television. Mr Dowell appeared to be still asleep, in the same position. He said that Mr Dowell did not usually wake up late but did so occasionally, so he was not worried about him. The cellmate got out of bed at around 11.00am and started tidying the cell.

71. Wing staff unlocked Mr Dowell's cell at 11.37am for lunch. The cellmate said he tried to wake Mr Dowell up to collect his lunch. He shook his leg (through the quilt cover) and called out to him. Mr Dowell did not respond or move. He left the cell and returned a few minutes later.

72. At 11.45am, the cellmate left their cell again with two plates as he was going to collect Mr Dowell's lunch too, as he said he thought he was still asleep.

73. An officer told us that shortly afterwards, he saw the cellmate at the servery with two meal plates. He asked him why he was collecting an additional plate of food as prisoners were not allowed to do this. The cellmate said that he was collecting a meal for his cellmate who was not feeling well. The officer allowed him to do so.

74. When the cellmate returned to the cell at 11.52am, he spoke to Mr Dowell and joked about him being lazy to get his attention. Mr Dowell did not respond so he threw bits of food from his dinner plate at him but missed. He thought that Mr Dowell was either very tired and still sleeping or had not wanted to talk to him.

75. At 11.54am, an officer completed a roll check. He saw the cellmate standing in the cell and Mr Dowell apparently asleep in his bed. He said that he had no concerns about Mr Dowell and, as he had a cellmate, he would have expected the cellmate to tell staff if something was wrong. He also said that it was not unusual for some prisoners to remain in their beds and not collect their lunch.

76. Officer C started unlocking those prisoners who had cleaning jobs. He arrived at Mr Dowell's cell at 12.35pm to collect him. The officer was with two other prisoners, who stood at the end of the landing. He opened the cell door and saw Mr Dowell and the cellmate lying in their beds. He called out to Mr Dowell and told him to get ready for work. Mr Dowell did not respond nor move. The cellmate told him that Mr Dowell had been asleep all morning. He asked the cellmate to wake him up. The cellmate got out of bed and tried to wake him. He shook his leg, shoulder and called out his name. Mr Dowell did not respond. The cellmate pulled the quilt off Mr Dowell. He said he was unsure if Mr Dowell was breathing.

77. At 12.36pm, Officer C entered the cell. He said Mr Dowell was lying on his front, with his head facing outwards. His eyes were closed, and his arms were under his body. He did not respond to his calls. He then left the cell to escort the other two prisoners away. He shouted to another officer who was on the wing to assist. He returned to Mr Dowell's cell a minute later. The officer arrived ten seconds later and saw Officer C checking Mr Dowell for any signs of life. He could not find a pulse. The officer then removed the cellmate from the cell. Officer C said he radioed a code blue emergency. The control room recorded that the emergency call was made at 12.39pm and an ambulance was called immediately.

78. An officer responded within one minute. She helped the officers move Mr Dowell onto his back to check for signs of life. None were found. She said that Mr Dowell looked like he was sleeping but his body was cold, rigid and hard to move. Officer C then started cardiopulmonary resuscitation (CPR) by doing chest compressions but stopped after around ten seconds as it was clear that Mr Dowell was dead.

79. By 12.40pm, CCTV footage shows that other staff responded, including a prison paramedic, a nurse and a CM. The prison paramedic examined Mr Dowell, noted there were no signs of life and that rigor mortis was present. He pronounced that Mr Dowell had died at 12.45pm. Ambulance paramedics arrived at 1.02pm.

Contact with Mr Dowell's family

80. Bullingdon identified Mr Dowell's partner as his next of kin. The prison initially appointed an officer as the prison's family liaison officer (FLO). Due to the COVID-19 pandemic, Bullingdon asked Leicestershire Police to break the news of his death to his partner. They did so that evening (25 May).

81. The FLO recorded in the family liaison log that she had spoken to Mr Dowell's next of kin on 28 May. She did not record a reason for the delay. She offered support and discussed next steps. Another officer took over family liaison duties from 2 June. She noted that she tried to contact Mr Dowell's partner on 2, 3 and 4 June, however, no one answered the phone. She phoned Mr Dowell's partner on 11 June and again no one answered the phone. On 23 June, she spoke to Mr Dowell's partner and discussed returning his property and funeral arrangements. The next day, another officer further spoke to Mr Dowell's partner about funeral arrangements. The prison contributed towards the cost of Mr Dowell's funeral in line with national instructions.

Support for prisoners and staff

82. After Mr Dowell's death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

83. The prison posted notices informing other prisoners of Mr Dowell's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Dowell's death.

Post-mortem report

84. The post-mortem examination was unable to determine the cause of Mr Dowell's death. While PS, cannabis and alcohol were found in his system, the pathologist could not ascertain if any of these substances contributed to or caused his death. The post-mortem, histology and toxicology reports provided no evidence that Mr Dowell's death was linked to COVID-19.

Other information

85. After Mr Dowell's death, the police found ibuprofen and mirtazapine in Mr Dowell's cell, neither of which had been prescribed to him.

86. The police also found a mandatory drug testing form, which belonged to his cellmate, and a vial of urine hidden within the stitching of clothing in a cupboard on Mr Dowell's cellmate's side of the room. (Prisoners who are using drugs may hide a vial of 'clean' urine on them in case they are asked to provide a urine sample as part of a drugs test.)

Findings

Mr Dowell's risks

87. Toxicology tests showed that Mr Dowell had used cannabis and PS sometime before he died, as well as having drunk hooch. However, the post-mortem was unable to ascertain if these substances, individually or combined, had caused or contributed to Mr Dowell's death.

88. Despite being found with hooch once in December 2019, prison staff had not identified Mr Dowell as having substance misuse issues and said they had never seen him under the influence of illicit substances.

89. There is no evidence that Mr Dowell wanted to take his life or harm himself at that time, and his cause of death is unascertained.

Roll checks

90. The officer on duty on the night of 24 to 25 May did not check Mr Dowell by looking into his cell during the roll check, as he should have. Bullingdon's local night instructions say that staff are expected to complete a visual check of all prisoners during a roll check. We recognise that a roll check is primarily to count prisoners to ensure that they are present in their cells for security purposes, but it is also an opportunity for staff to identify and address any concerns about prisoners' safety. While the failure to conduct the night roll check properly on this occasion was unlikely to have had an impact on the outcome for Mr Dowell, it might be critical in other circumstances. We make the following recommendation:

    The Governor should ensure that staff understand their responsibilities when completing roll checks and that roll checks are properly carried out in line with local procedures.

Unlock procedures

91. The Prison Officer Entry Level Training (POELT) manual says that before unlocking a cell, staff should physically check that the prisoner is present. It says that staff must ensure that they receive a positive response from the prisoner by knocking on the door and waiting for a sign of acknowledgment. The manual says that if staff do not get a response, they may need to open the cell to check that the prisoner has not escaped, is not ill or dead.

92. Prison Service Instruction 75/2011 on residential services says that:

    "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable... "

    "…there needs to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process."

93. Staff at Bullingdon also told us that their local policy required them also to conduct welfare checks at around 7.30am when officers carry out the 'breakfast pack round'. The local policy says, "Officers unlock, open and enter cells to place the breakfast pack inside. Staff must engage with the prisoner and be satisfied about his welfare".

94. The OSG completed the morning roll check correctly on 25 May. At the morning unlock at 8.02am, an officer failed to conduct a proper welfare check while placing breakfast in Mr Dowell's cell. He told the investigator that neither Mr Dowell or his cellmate responded when he briefly went into the cell and he made no additional attempt to obtain a response from them.

95. Staff twice returned to Mr Dowell's cell that morning but paid little attention to him and interpreted his lack of response as him being asleep. Mr Dowell's cellmate had also thought this. Another officer unlocked Mr Dowell's cell at around 11.30am and called into the cell for the occupants to collect their lunch. This was another missed opportunity to check on Mr Dowell when he did not respond or leave the cell.

96. We are concerned that despite a roll check at 4.45am on 25 May, a subsequent morning check at 8.02am, offering both prisoners in Mr Dowell's cell a shower at 8.15am and doing a fabric check at 9.21am, no one noticed that Mr Dowell had not responded on each occasion. Staff missed many opportunities to check on Mr Dowell's welfare before he was found unresponsive in his cell at 12.36pm. The clinical reviewer concluded that Mr Dowell died several hours before he was discovered.

97. We cannot know whether earlier intervention would have affected the outcome for Mr Dowell but, in other circumstances, it could be critical. We make the following recommendation:

The Governor should ensure that when cell doors are unlocked, staff satisfy themselves that prisoners are safe and that there are no immediate issues that need attention.

98. We are also concerned that staff appear to have made very little effort to engage with Mr Dowell and his cellmate on the occasions when they unlocked their cell on the morning of Mr Dowell's death. We appreciate that staff are be busy but these opportunities to check on prisoners' wellbeing and to identify any concerns (including possible signs of mental health problems or substance misuse) are particularly important in prisons during the COVID lockdowns.

Bullingdon's drug strategy

99. Mr Dowell and a prisoner who died at Bullingdon in July 2020 had used illicit substances before their deaths. It is troubling that Mr Dowell was able to access hooch, PS and cannabis, particularly during the COVID-19 lockdown when severe restrictions had been put in place on prisoner and visitor movement.

100. There was a national instruction from HMPPS in April 2019 that all prisons should review their drug strategy. HM Inspectorate of Prisons expressed concern at the easy availability of drugs at Bullingdon when they completed their inspection in July 2019. Since this date, Bullingdon has made strenuous efforts to ensure support for prisoners with substance misuse and to reduce the supply and demand for illicit

substances. Bullingdon revised its Drug Strategy meetings and completed a Reducing Reoffending Needs Analysis in March 2020 to understand the needs of the prison's population, looking at the pathways to reduce reoffending, including substance misuse. However, it has not yet produced a revised Drug Supply and Demand Reduction Strategy, which was delayed because of the COVID-19 pandemic. This work needs to be revived and properly addressed.

Emergency response

101. We are concerned that when Officer A could not get a response from Mr Dowell when he first entered his cell at 12.36pm, he did not act with sufficient urgency and failed to radio a code blue emergency immediately. This was not done until three minutes later, after he had left the cell and returned with another officer.

102. While the delay in calling a code blue would have made no difference to the outcome for Mr Dowell, such delays could be critical in other life-threatening situations. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code.

Liaison with Mr Dowell's next of kin

103. PSI 64/2011 on safer custody requires prison staff to communicate with the next of kin of prisoners who are seriously or terminally ill and following death. Mr Dowell's partner was unhappy about Bullingdon's contact with her after his death as she said they failed to contact her on numerous occasions. Mr Dowell's partner emailed the prison family liaison officer on 2 September and told them that she had been trying to contact her for two months but to no avail.

104. The investigator reviewed the prison family liaison log and email correspondence. These did not provide a clear, chronological or concise record of contact with Mr Dowell's partner after his death and important contact information was not recorded in the family liaison log. It also highlighted that the prison family liaison officer was absent from the prison for four weeks and no one contacted Mr Dowell's partner in her absence.

105. It is important that prisons have contingency plans in place to cover staff absences so they can maintain contact with bereaved families. A deputy family liaison officer should have been appointed at the outset to ensure continuity of contact with Mr Dowell's family. We make the following recommendation:

The Governor should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.

Clinical care

106. The clinical reviewer noted that, overall, the mental and physical healthcare that Mr Dowell received in prison was equivalent to that which he could have expected to receive in the community.

Recognising signs of death

107. It was clear that Mr Dowell was dead when staff found him and the decision not to perform CPR was taken quickly and appropriately. However, an ambulance had already been called and was not cancelled because ambulance paramedics were required to confirm Mr Dowell's death.

108. Current guidelines (including the emergency COVID-19 guidelines) do not permit nurses to verify any deaths that occur in prison. The clinical reviewer suggested that prison healthcare at Bullingdon should develop a process to ensure that staff know how to recognise and pronounce death. This would negate the need to request an emergency ambulance to attend the prison to do so, particularly as the ambulance service's resources are so stretched and they would not be able to offer meaningful assistance to save a life.

109. We agree with the clinical reviewer that this would be desirable. However, we recognise that this is a complex issue, and we consider that this would be best dealt with through local procedures, with a view to introducing a national framework in the longer term. We therefore make the following recommendation.

Practice Plus Group Health and Rehabilitation Services Limited and the Head of Healthcare at Bullingdon should:

- **review the role of paramedics working within the prison in relation to undertaking recognition of life extinct (ROLE). If appropriate, this should include the provision of local operating procedures and supporting paperwork and ensure all staff are aware;**
- **and update the Ombudsman within six months on progress made.**

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