Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Bowering, a prisoner at HMP Whatton, on 18 May 2022

A report by the Prisons and Probation Ombudsman

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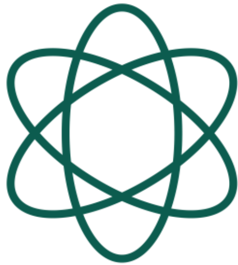
Our vision

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

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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 Dennis Bowering, who was 75 years old, died in hospital of acute pulmonary oedema (excess fluid on the lungs) on 18 May 2022, while a prisoner at HMP Whatton. We offer our condolences to Mr Bowering's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Bowering received at HMP Whatton was equivalent to that which he could have expected to receive in the community. She made recommendations about noting all pre-existing conditions during initial health screens, carrying out a secondary health screen in line with the National Institute for Clinical Excellence (NICE) guidance and updating care plans, which we do not repeat here but which the Head of Healthcare will need to address.

5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Bowering's clinical care at HMP Whatton.

7. The PPO investigator investigated the non-clinical issues relating to Mr Bowering'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 Bowering's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whatton

10. Mr Bowering was the fourteenth prisoner to die at Whatton since May 2020. Of the previous deaths, twelve were from natural causes and one was self-inflicted.

11. In a previous investigation into the death of a prisoner at Whatton in June 2021, we made recommendations about initial and secondary health screens being completed in line with NICE guidance. The prison accepted our recommendation and said that from February 2021, first and secondary health screens would be conducted separately. It is concerning that we have identified similar issues again in this report.

Key Events

12. On 28 September 1983, Mr Dennis Bowering was sentenced to life imprisonment for murder. He received a minimum tariff of 25 years. He was sent to HMP Manchester. On 6 July 2021, Mr Bowering was transferred to HMP Whatton.

13. In 2014, Mr Bowering was diagnosed with cancer. He had a surgical procedure to remove his bladder and kidney. As a result, he used a urostomy bag (a bag used to collect the urine from the abdomen). Mr Bowering was also diagnosed with cavernoma in his temporal lobe (a cluster of abnormal blood vessels usually in the brain or spinal cord), COPD (the name given to a collection of respiratory diseases) and raised blood pressure. He also had mobility issues and used a wheelchair to move around.

2021

14. Prior to his transfer to Whatton, Mr Bowering fractured his left wrist, which was in a plaster cast. A nurse carried out his initial health screen and noted his pre-existing medical conditions. She referred Mr Bowering to the neurosurgical, cardiology and urology departments at the hospital and to the fracture clinic to ensure continuity of his care. She created care plans to manage his raised blood pressure and COPD, and referred him to the prison's long-term condition clinic. Healthcare staff reviewed Mr Bowering regularly.

15. On 27 August 2021, a prison GP saw Mr Bowering. He carried out full blood tests. The results indicated that Mr Bowering was at risk of developing diabetes. The GP referred him to the prison's diabetic clinic for ongoing monitoring.

16. On 26 October, another prison GP saw Mr Bowering. He told her that he had been experiencing ongoing bouts of dizziness. The GP noted that the cardiology team at the hospital were aware of this and were providing ongoing monitoring. However, she considered that it would be beneficial to carry out an electrocardiogram (ECG, used to assess the electrical output of the heart). Mr Bowering also told the GP he had been experiencing rectal bleeding. The GP asked that he make another appointment with her for a rectal examination.

17. The following day, staff called a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) because Mr Bowering had a fever and lower right back pain. Paramedics arrived and took him to hospital for further review. Mr Bowering was diagnosed with a urine infection and was prescribed with a course of antibiotics. He was discharged from hospital and returned to Whatton later that day.

18. On 2 November, a prison GP saw Mr Bowering. She carried out an ECG and the results showed that he had an abnormal heart rhythm. She noted he was due a routine review by hospital staff to include a further ECG, so did not make another referral. Mr Bowering told her that he was still experiencing rectal bleeding after passing stools. Following an examination, she diagnosed him with haemorrhoids. He continued to be reviewed regularly in the months that followed.

2022

19. On 6 May 2022, a nurse saw Mr Bowering. He told her that he was still experiencing rectal bleeding after passing stools but was not experiencing any pain. The nurse referred him for a GP review. On 17 May, a prison GP carried out a faecal immunochemical test (used to identify traces of blood in faeces, often an early indicator of possible colon or bowel cancer), full blood tests and an ECG. She planned to review him once the results were available.

20. At 5.00am on 18 July, Mr Bowering told staff that he was experiencing chest pains and a shortness of breath. Staff radioed a medical emergency code blue and control room staff telephoned for an emergency ambulance immediately.

21. At 5.30am, paramedics arrived, and Mr Bowering was taken to hospital. Mr Bowering was admitted to hospital as an inpatient and was moved to the cardiac care unit. Chest X-ray results showed that he had fluid on the lungs.

22. Mr Bowering's condition continued to deteriorate and at 10.55pm he had a cardiac arrest. Hospital staff commenced cardiopulmonary resuscitation but were unsuccessful. At 11.06pm, a hospital doctor confirmed that Mr Bowering had died.

Cause of death

23. The Coroner accepted the cause of death provided by a doctor and no post-mortem examination was carried out. The doctor gave Mr Bowering's cause of death as acute pulmonary oedema (excessive fluid in the lungs) caused by aortic stenosis and acute coronary syndrome (a range of conditions associated with sudden, reduced blood flow to the heart) and ischaemic heart disease. He also had cancer of the bladder and kidney, frailty, hypertension (raised blood pressure) and asthma, which were listed as contributory factors.

Lisa Burrell
Assistant Prisons and Probation Ombudsman **December 2022**

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