

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Wesley Bowen,
a prisoner at HMP Bristol,
on 25 February 2022**

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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

OGI

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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.
1. Mr Wesley Bowen died in hospital from sepsis on 25 February 2022, while a prisoner at HMP Bristol. He was 43 years old. We offer our condolences to Mr Bowen's family and friends.
2. The clinical reviewer concluded that the clinical care Mr Bowen received at Bristol was equivalent to that which he could have expected to receive in the community. He made no recommendations.
3. We found that the medical section of the escort risk assessment for Mr Bowen's transfer to hospital on 20 February was not completed accurately. This meant that the authorising manager took the decision to authorise restraints without an accurate account of Mr Bowen's current medical condition.

Recommendations

- The Head of Healthcare should ensure that healthcare contributions to escort risk assessments are accurate, sufficiently detailed and reflect the prisoner's current medical condition.

The Investigation Process

4. NHS England commissioned an independent clinical reviewer to review Mr Bowen's clinical care at HMP Bristol.
5. The PPO investigator has investigated non-clinical issues, including Mr Bowen's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
6. The PPO family liaison officer wrote to Mr Bowen's next of kin, his mother, to explain the investigation. She did not respond to our letter.
7. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. The action plan is annexed to this report.

Previous deaths at HMP Bristol

8. Mr Bowen was the fifth prisoner to die at Bristol since February 2020. Of the previous deaths, three were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Bowen's death and our investigation findings for the previous deaths.

Key Events

9. On 16 October 2020, Mr Wesley Bowen was remanded in prison custody, charged with theft and drug offences, and sent to HMP Bristol. In December, he was sentenced to four years and four months in prison.
10. Mr Bowen had already been diagnosed with lymphoma (a type of cancer that develops in the lymphatic system) when he arrived at Bristol. He underwent his first round of chemotherapy between December 2020 and March 2021.
11. On 13 July 2021, hospital doctors concluded that Mr Bowen's previous cancer treatment had not worked as effectively as they had hoped, and decided to try a different, more aggressive course of chemotherapy. Mr Bowen began his second round of chemotherapy on 18 July.
12. On 29 July, healthcare staff suspected Mr Bowen had neutropenic sepsis (a whole-body reaction to an infection) and arranged for him to go to hospital. Mr Bowen discharged himself against medical advice on 3 August. Prison doctors prescribed antibiotics.
13. On 26 November, hospital doctors reviewed Mr Bowen and diagnosed him with neutropenic sepsis. Mr Bowen declined the recommended treatments but did accept a course of antibiotics.
14. On 5 February, Mr Bowen began his third round of chemotherapy. He was discharged back to Bristol on 10 February.
15. On 20 February, a nurse visited Mr Bowen to take some blood, but he refused because he felt too unwell. The nurse noted he was clammy and took his observations. Prison staff arranged for an ambulance to take Mr Bowen to hospital, in line with his cancer care plan. The ambulance arrived at 5.09pm but Mr Bowen refused to go to hospital.
16. At 7.22pm, a nurse spoke to Mr Bowen about his observations and told him that he was very unwell and that he may die. Mr Bowen continued to refuse to go to hospital. The nurse sought advice from Mr Bowen's oncologist who recommended fluids and an ECG (a test that checks the heart's rhythm). A paramedic arrived at 7.45pm to do the ECG, but Mr Bowen refused.
17. At 8.50pm, a nurse noted that Mr Bowen was continuing to deteriorate and gave him oxygen. The nurse explained to Mr Bowen that he was seriously unwell and that there was no further treatment prison healthcare staff could offer, and that hospital admission was the only next step. Mr Bowen agreed to go to hospital.
18. Prison staff called for an ambulance at 9.10pm, which arrived at 10.00pm. During this time Mr Bowen fell while trying to go to the toilet, and prison healthcare staff noted he had begun to peripherally shut down (his circulation had begun to fail in his outlying arteries and veins). At 10.20pm, the ambulance left with Mr Bowen who was on oxygen. Hospital staff admitted Mr Bowen to the Intensive Care Unit and placed him on a ventilator (a machine used to help a patient breathe).
19. On 22 February, Mr Bowen was released on temporary licence. Mr Bowen continued to deteriorate and died in hospital on 25 February.

Cause of death

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Bowen's cause of death as multi-organ failure caused by neutropenic sepsis. He also had a relapse of non-Hodgkin's lymphoma, which did not cause but contributed to his death.

Non-Clinical Findings

Restraints, security and escorts

21. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

22. The investigator reviewed Mr Bowen's escort risk assessment from 20 February 2021. A member of healthcare staff had noted on the form that Mr Bowen had suspected neutropenic sepsis, but they had also noted that there were no medical conditions that were likely to influence the escort or any escape potential. This was inaccurate as by the time Mr Bowen was taken to hospital, he was critically unwell and on oxygen. This meant that the authorising manager took the decision to authorise restraints without an accurate account of Mr Bowen's current medical condition. We recommend:

The Head of Healthcare should ensure that healthcare contributions to escort risk assessments are accurate, sufficiently detailed and reflect the prisoner's current medical condition.

Louise Richards
Assistant Ombudsman

November 2022

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