

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Peter Rowley, a prisoner at HMP Hewell, on 26 May 2022**

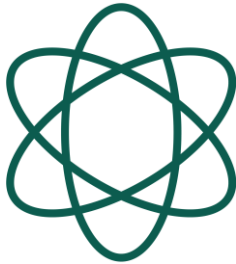
**A report by the Prisons and Probation Ombudsman**

## 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

**OGL**

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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 Peter Rowley died on 26 May 2022 of acute left ventricular failure (heart failure) caused by dilated cardiomyopathy (heart disease) while a prisoner at HMP Hewell. He was 80 years old. We offer our condolences to Mr Rowley's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Rowley received at Hewell was of a good standard and at least equivalent to that which he could have expected to receive in the community. On the night that Mr Rowley died, there was a delay before prison staff opened his cell and provided emergency medical assistance.

## Recommendations

- The Governor should ensure that staff are made aware of and understand their responsibilities during a medical emergency, including that they go into cells as quickly as possible in a potentially life-threatening situation.

## The Investigation Process

5. NHS England commissioned an independent clinical reviewer to review Mr Rowley's clinical care at Hewell.
6. The investigator issued notices to staff and prisoners at Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator visited HMP Hewell and interviewed two members of staff on 23 September 2022. She interviewed one member of staff virtually on 6 October.
8. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at HMP Hewell

10. Mr Rowley was the ninth prisoner to die at Hewell since May 2020. Of the eight previous deaths, three were self-inflicted and five were from natural causes. There has been one self-inflicted death since Mr Rowley died.
11. There are no similarities between our findings in the investigation into Mr Rowley's death and our investigation findings for the previous deaths.

## Key Events

11. On 30 December 2014, Mr Peter Rowley was remanded in custody for sex offences. He was later sentenced to ten years in prison.
12. On 30 December 2019, Mr Rowley was released from prison on licence.
13. On 3 March 2022, Mr Rowley was recalled to prison after breaching his licence conditions. He was sent to HMP Hewell.
14. Mr Rowley was diagnosed with several significant medical conditions, including hypertension (high blood pressure), asthma, various heart conditions, a kidney injury, and a fatty liver. He was also undergoing dementia assessment. Mr Rowley had a below knee amputation and used a wheelchair to move around. He received support with his daily living activities.

## Events of 25-26 May 2022

15. At around 8.36pm on 25 May, Mr Rowley pressed his cell bell. Officer A spoke to him through the cell observation panel and told us that Mr Rowley was confused and wanted to leave. He said that there were suspicions that Mr Rowley had dementia and so this was not unusual.
16. CCTV footage shows that between 10.00pm and 2.00am, Officer A regularly walked towards Mr Rowley's cell whilst completing other duties. He appeared to look into the cell for a few seconds at a time.
17. At approximately 2.00am, Officer A noticed that Mr Rowley still had his light and television on. He looked through the observation panel into the cell and saw Mr Rowley asleep. He said that he could hear snoring which he believed to be Mr Rowley.
18. At approximately 3.05am, Officer A went to Mr Rowley's cell because he saw that Mr Rowley's light and television were still on. On this occasion, Officer A called his name and did not get a response, nor could he see any movement or breathing. He spoke to another officer, who was also working on the wing, to get another opinion. The officer went to Mr Rowley's cell and checked to see if he could see breathing but could not tell.
19. At 3.09am, Officer A radioed a Custodial Manager (CM) to ask him to speak on the telephone. The officer asked him for advice and if it was okay to open the cell door. The CM asked the officer if it was a code blue and noted that he said he was not sure. The CM radioed for other staff to attend the wing to support entry to the cell.
20. At 3.19am, three officers arrived on the unit. The officers called Mr Rowley's name through the door but could not get a response. Officer A radioed a code blue medical emergency (indicating that a prisoner is unconscious or is having breathing difficulties). An Operational Support Grade in the control room called to request an emergency ambulance.

21. At 3.21am, the CM arrived at the cell and authorised the officers to enter. Officer A checked Mr Rowley and found that he was unresponsive and cold to touch. Officers moved Mr Rowley to the floor and commenced cardiopulmonary resuscitation.
22. A nurse and a Healthcare Assistant attended the scene and took over Mr Rowley's medical care.
23. At 3.40am, ambulance paramedics arrived at Hewell and, at 4.04am, they confirmed that Mr Rowley had died.

### **Contact with Mr Rowley's family**

24. Mr Rowley was not in contact with any family or friends and therefore did not have a registered next of kin.

### **Support for prisoners and staff**

25. After Mr Rowley's death, the Head of Security debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
26. Hewell posted notices informing all staff of Mr Rowley's death and reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rowley's death.

### **Post-mortem report**

27. A post-mortem examination established that Mr Rowley died from acute left ventricular failure (heart failure), caused by dilated cardiomyopathy (heart disease).

# Findings

## Clinical Findings

28. The clinical reviewer concluded that the care Mr Rowley received at HMP Hewell was of a good standard and was at least equivalent to that which would have been received in the wider community. She made three recommendations not directly related to Mr Rowley's death which the Head of Healthcare will need to address.

## Emergency response

29. Prison Service Instruction (PSI) 24/2011, on management and security at nights, requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night manager must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff (depending on local requirements) are present, one of whom should be the night manager. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night manager and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.
30. The PSI states that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.
31. When Officer A found Mr Rowley unresponsive in his cell, he could not see any sign of movement or breathing. Another officer also could not tell if Mr Rowley was breathing. Around ten minutes later, three officers arrived on the wing and radioed a medical emergency code blue, but there was a further two-minute delay until the CM arrived and the cell was opened.
32. While we recognise that it is difficult for staff to make instant decisions, when there is a potentially life-threatening situation it is essential to act quickly. Mr Rowley was an 80-year-old man who used a wheelchair to mobilise. There is little evidence of any significant risk were his cell to be opened at night by one officer, let alone two or more. Given that the staff could not ascertain whether Mr Rowley was breathing, on balance we would expect them to quickly go into the cell in case there was a chance of saving his life. We make the following recommendation:

**The Governor should ensure that staff are made aware of and understand their responsibilities during a medical emergency, including that they go into cells as quickly as possible in a potentially life-threatening situation.**

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