Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Dawson, a prisoner at HMP Holme House, on 11 March 2024

A report by the Prisons and Probation Ombudsman

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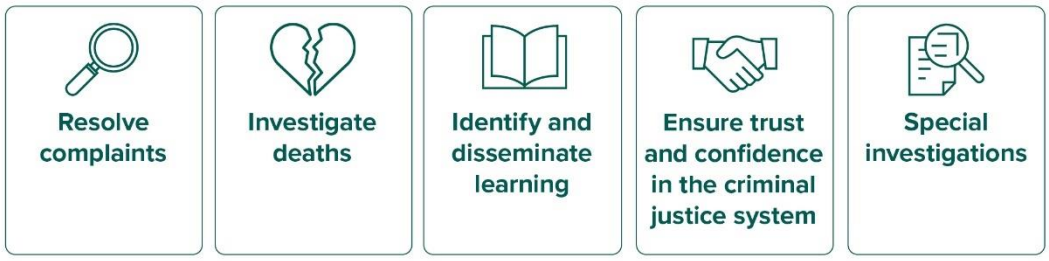
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr William Dawson died of metastatic cancer of the pancreas on 11 March 2024, while a prisoner at HMP Holme House. He was 73 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Dawson received at Holme House was of a good standard and at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations which were not related to Mr Dawson's death but which the Head of Healthcare will want to address.

5. It was particularly shocking that although Mr Dawson had had both legs amputated and posed a low risk, HMP Durham, Mr Dawson's previous prison, considered it appropriate to restrain him using an escort cable when he went to hospital two months before he died. Healthcare staff had not completed an escort risk assessment and were not always asked to contribute to the risk assessment process.

Recommendation

- **The Governor and Head of Healthcare at HMP Durham should ensure that all staff undertaking escort risk assessments understand the legal position on the use of restraints, that assessments fully take into account the current health, mobility and risk of a prisoner and that healthcare staff complete the medical sections accurately.**

- **The Governor of HMP Durham should ensure that a quality assurance process is implemented to satisfy himself that restraints decisions are credible, and all necessary parties are consulted.**

The Investigation Process

6. HMPPS notified us of Mr Dawson's death on 11 March 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Dawson's clinical care at HMP Holme House.

8. The PPO investigator investigated the non-clinical issues relating to Mr Dawson's care.

9. Mr Dawson had no recorded next of kin.

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

Previous deaths at HMP Holme House and HMP Durham

11. Mr Dawson was the twelfth prisoner to die at Holme House since March 2022. Of the previous deaths, 10 were from natural causes, and one was non-natural. There are no similarities between the findings in our investigation into Mr Dawson's death and the findings from our investigations into the previous deaths.

12. However, we have previously made recommendations to HMP Durham in two cases in early 2023 about the need for healthcare staff to contribute to the escort risk assessment process and for this to be properly documented when deciding whether or not to use restraints. Durham agreed to implement our recommendations.

Key Events

HMP Durham

13. On 9 January 2023, Mr William Dawson was sentenced to 27 years in prison for sex offences and sent to HMP Durham. He had a significant medical history, including chronic obstructive pulmonary disease. He had had both legs amputated above the knee and used a wheelchair.

14. On 5 January 2024, a doctor operating at Durham saw Mr Dawson for suspected jaundice. They advised that he needed to be admitted to hospital, but this could not be done until the following day due to prison staffing pressures.

15. Prison staff completed an escort risk assessment on 5 January and decided that, when he went to hospital, he should be restrained with a D-cuff escort cable (where a prisoner is restrained by a long metal cable with a cuff at either end, one of which is attached to the prisoner and the other to an officer). The escort risk assessment noted that there were no medical objections to restraining Mr Dawson but also that he was a double leg amputee, used a wheelchair, had 'reduced mobility', and was assessed as low risk for escape and harm to others.

16. The officer who completed the escort risk assessment told the investigator that healthcare staff had not been asked to complete the medical section of the risk assessment and he could not recall if he had spoken to healthcare staff about Mr Dawson. Instead, he had completed some details using the alerts from Mr Dawson's prison records but could not recall whether he completed the section to say there were no medical objections to the use of restraints.

17. The Head of Business Assurance at the time, and the authorising manager, told us that she authorised the use of an escort cable because Mr Dawson was a sex offender and consideration had to be given to his risk to others. She said that an escort cable was used as opposed to other forms of restraints because he was a double leg amputee.

18. On 6 January, Mr Dawson was admitted to hospital for suspected obstructive jaundice (which is caused by a blocked bile or pancreatic duct), restrained with an escort cable.

19. On 9 January, Mr Dawson's restraints were removed in hospital. The bed watch log stated that this was because Mr Dawson was a double leg amputee and there was no security intelligence about him.

20. On 11 January, a hospital doctor told Mr Dawson that he had inoperable pancreatic cancer. He was discharged to Durham on 16 January, unrestrained for the journey back to the prison.

HMP Holme House

21. On 21 January, Mr Dawson was transferred to the healthcare unit at HMP Holme House as he needed palliative care. He was not restrained for any visits to hospital for cancer treatment.

22. On 31 January, Mr Dawson's palliative care treatment began, and healthcare staff discussed his end-of-life care with him. He signed an order not to be resuscitated if his heart or breathing stopped.

23. On 5 February, Mr Dawson became confused and was admitted to hospital, where he was diagnosed with biliary sepsis and acute kidney injury. He was treated with intravenous antibiotics.

24. On 9 February, Mr Dawson was discharged from hospital to Holme House and told that he may need palliative chemotherapy.

25. On 3 March, nursing staff found Mr Dawson drowsy and slumped in his chair. He was admitted to hospital again for biliary sepsis and acute kidney injury. Although he was given antibiotics, his health continued to deteriorate.

26. He was discharged on 9 March to Holme House and moved to the palliative care suite for end-of-life care. A hospital consultant told prison staff that Mr Dawson had a prognosis of a few days.

27. At approximately 6:40pm on 11 March, Mr Dawson died.

Post-mortem report

28. A hospital doctor established that Mr Dawson had died from metastatic cancer of the pancreas. He also had peripheral vascular disease (a disease where circulation to a body part is reduced due to a blocked or narrowed vessel), hypertension and chronic obstructive pulmonary disease which contributed to but did not cause his death. The Coroner accepted the cause of death, and no post-mortem examination was carried out.

Inquest

29. At an inquest held on 9 October 2024, the Coroner concluded that Mr Dawson died of natural causes.

Non-Clinical Findings

Restraints, security and escorts

30. 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.

31. A judgment in the High Court in 2007, known as the Graham judgment, 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 he has a serious medical condition. It said 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. The Prevention of Escape: External Escorts policy framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and disability.

32. On 6 January, while at HMP Durham, Mr Dawson was taken to hospital for suspected jaundice, restrained with an escort cable. Mr Dawson was 73 years old. He used a wheelchair, as he was a double leg amputee, and he was a Category C prisoner. His risk level was assessed as low in all areas, with no intelligence to suggest there was a risk of escape or harm to staff. He was an enhanced prisoner who had had no previous disciplinary hearings. Mr Dawson had no family contact which might have further reduced his risk of escape.

33. An officer told the investigator that he completed the medical section of the risk assessment using information from Mr Dawson's prison records. This section did not note that Mr Dawson was a double leg amputee. He could not recall if he had spoken to healthcare staff or if they had contributed to the risk assessment, but the risk assessment noted no medical objections to restraints.

34. The Head of Business Assurance told the investigator that the decision to use an escort cable was in the interests of decency, as well as the health and safety of staff. The Head of Healthcare told us that the prison often did not ask healthcare staff to complete escort paperwork at the time and she did not want staff to sign such paperwork when a prisoner's clinical condition could subsequently change, and they could be liable for the decision. She also told the investigator that healthcare staff were not always consulted on the use of restraints if the prison did not consider it necessary.

35. As a result, Mr Dawson's severely limited mobility as a double amputee was not taken into account when deciding to restrain him. This decision was unjustified and not in line with the policy framework, particularly as he was identified as posing a low risk of escape and harm to others and he was escorted by two officers.

36. We have previously made recommendations to the Governor of HMP Durham in January and February 2023 about the inappropriate use of restraints and about the need for healthcare staff to complete the escort risk assessment appropriately.

Durham accepted our recommendations and agreed to ensure clinical staff complete the escort risk assessment properly and review and amend the risk assessment form on a trial basis. However, this case demonstrates that significant issues with the inappropriate use of restraints remain that must be addressed, and it is clear that greater oversight and closer monitoring of decisions is needed. We make the following recommendations:

The Governor and Head of Healthcare at HMP Durham should ensure that all staff undertaking escort risk assessments understand the legal position on the use of restraints, that assessments fully take into account the current health, mobility and risk of a prisoner and that healthcare staff complete the medical sections accurately.

The Governor of HMP Durham should ensure that a quality assurance process is implemented to satisfy himself that restraints decisions are credible, and all necessary parties are consulted.

Governor to note

37. HMP Durham continue to use their own template for the escort risk assessment. This is contrary to the Prevention of Escape: External Escorts Policy Framework which requires prisons to use the risk assessment template which is annexed to the policy. The Governor of HMP Durham will wish to review this practice.

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Prisons and Probation Ombudsman **October 2024**

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