Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Azroy Dawes-Clarke, a prisoner at HMP Elmley, on 10 November 2021

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

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.

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.

Mr Azroy Dawes-Clarke, a black British man, died on 10 November 2021, at HMP Elmley. His cause of death was complex and recorded by the pathologist as hypoxic ischaemic brain injury, due to cardio-respiratory arrest, in close proximity to a period of third-party restraint, shortly after an apparent seizure following compression of the neck by a ligature. He was 28 years old. I offer my condolences to Mr Dawes-Clarke's family and friends.

The circumstances of Mr Dawes-Clarke's death are concerning. Force was used on him twice in the time before he died. The first occasion seemingly triggered a chain of events in which Mr Dawes-Clarke tried to take his life three times in a little over two weeks. The second occasion occurred immediately after staff found him with a ligature around his neck, which prompted a confused response in which Mr Dawes-Clarke's physical symptoms of seizure and incoherence were mistaken for aggression. Mr Dawes-Clarke stopped breathing during this use of force and died shortly afterwards.

Suicide and self-harm prevention procedures (known as ACCT), which were initiated when Mr Dawes-Clarke first tried to take his life, were also confused. Some aspects that are usually reserved for those judged to be at the greatest risk – such as using alternative (anti-ligature) clothing and unfurnished (special) accommodation – were implemented, but alongside a frequency of observations usually used for those judged to be at less immediate risk. There was no management oversight or authorisation of the use of alternative clothing or unfurnished accommodation, which is likely to have added to the confusion about how best to manage Mr Dawes-Clarke's risk.

I am conscious that this report will make distressing reading for Mr Dawes-Clarke's family. While his cause of death is particularly complex, there were critical missed opportunities to adequately manage his circumstances and I cannot say that better decisions would not have led to a different outcome.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

Contents

Summary

Events

1. On 23 April 2020, Mr Azroy Dawes-Clarke was recalled to prison, having breached his licence by committing a further offence. He was taken to HMP Elmley. On 2 June 2021, Mr Dawes-Clarke was sentenced to seven years and nine months imprisonment for robbery. He had been to prison several times before.

2. Mr Dawes-Clarke had a long history of self-harm and suicide attempts, including the tying of ligatures, throughout his time in prison. He also had several physical health conditions that required ongoing treatment to manage his symptoms.

3. On 25 October 2021, Mr Dawes-Clarke refused an order to return to his cell after collecting his medication. He then began to walk slowly towards his cell, during which time staff used force on him. Shortly afterwards, Mr Dawes-Clarke tied a ligature around his neck and said that he had intended to end his life. After this incident, Mr Dawes-Clarke's mental health appeared to deteriorate. Staff started suicide and self-harm prevention procedures (known as ACCT).

4. On 8 November, Mr Dawes-Clarke was taken to hospital as he was physically unwell. He was returned to Elmley after threatening a doctor. Later that day, Mr Dawes-Clarke was extremely upset; he told staff that his sister had been in an accident (this information was not correct).

5. On 9 November, Mr Dawes-Clarke barricaded his cell and tied a ligature around his neck. He pressed his cell bell and staff responded. Mr Dawes-Clarke said he felt under threat and that other prisoners were going to harm him, and that he wanted to end his life. Staff placed Mr Dawes-Clarke in alternative (anti-ligature) clothing, and he was moved to Elmley's inpatient unit, in a cell with a bed but no other furniture or bedding (known as special accommodation). Mr Dawes-Clarke remained in alternative clothing and special accommodation until he died.

6. At around 4.40pm on 10 November, a healthcare assistant responded to Mr Dawes-Clarke's emergency cell bell and found him lying on the floor of his cell with a ligature tied around his neck. She alerted nearby officers, who responded and radioed a medical emergency. Mr Dawes-Clarke appeared to be having a seizure and prison doctors treated him with diazepam. They handed over care to paramedics when they arrived.

7. Prison staff and paramedics decided to put clothes on Mr Dawes-Clarke before he was taken to hospital. While trying to dress Mr Dawes-Clarke, he became agitated and lashed out. Staff believed that this was intentional (although it is unclear if this was the case), and they used force to gain his compliance. Handcuffs were applied, but he became unresponsive almost immediately afterwards. Healthcare staff started cardiopulmonary resuscitation (CPR). Paramedics continued resuscitation and Mr Dawes-Clarke was taken to hospital. On the journey to the hospital, Mr Dawes-Clarke went into cardiac arrest. At 8.13pm, hospital staff declared that he had died.

Findings

8. The ACCT procedures were poorly managed and did little to reduce Mr Dawes-Clarke's risk. Observations, particularly in the last 24 hours of Mr Dawes-Clarke's life, were not appropriate to his level of risk and support actions – which should direct and enable staff to reduce risk – were minimal and ineffective. Some aspects of national policy around the use of special accommodation were not followed, including that there is no evidence that this was authorised by an operational manager.

9. In the time before he died, force was twice used on Mr Dawes-Clarke. On one occasion without proper justification and when it was not reasonable, necessary or proportionate to the circumstances. The second of these events immediately preceded Mr Dawes-Clarke's death, and included some techniques that are considered dangerous and are not advised by national trainers. The overall management of this incident was particularly poor, with a lack of clear direction or involvement of healthcare staff or attending paramedics either before, during or immediately after Mr Dawes-Clarke became unresponsive.

Recommendations

- The Governor should investigate the quality of and compliance with policy of ACCT management, including the use of alternative clothing and special accommodation, in the previous 12 months, identify any improvements required, and devise a robust plan to deliver those improvements.

- The Governor and Head of Healthcare should ensure that there is clear guidance and training for all staff on the safe use of force, in particular on all risk factors in relation to positional asphyxia, that they understand the circumstances in which force is reasonable and justified, and that they are empowered to intervene when they feel the need to do so.

- The Governor and Head of Healthcare should ensure that clinical staff are consulted whenever possible before a use of force and attend any unplanned use of force as soon as possible, especially where a prisoner has already experienced a medical emergency.

- The Governor should commission the National Incident Management Unit to review the use of force on 25 October 2021, and implement any recommendations they make.

- The Head of Healthcare should ensure that there is always a registered nurse or a GP present during a medical emergency. Guidance on the role of GPs and senior managers during an emergency should be developed, detailing guidance on leadership, handover and what staff must do before they return to their usual duties or leave the prison.

- The Head of Healthcare should ensure that all healthcare staff understand their role in an emergency response, including recognising and managing seizures or loss of consciousness in line with current clinical guidelines, and recording actions taken. A

local protocol, in line with NICE Guidance should be developed and training provided to ensure staff at all levels understand what is required.

- NHS England and SECAmb should conduct an investigation into the circumstances surrounding Mr Dawes-Clarke's resuscitation, including the actions of paramedics in attendance.

- The Governor and Head of Healthcare should ensure that all staff involved in a death in custody, and those that are identified as significant to the deceased, should be offered support in line with Postvention procedures.

The Investigation Process

10. HMPPS notified us of Mr Dawes-Clarke's death on 11 November 2021.

11. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. We received a letter from one prisoner in response asking to speak to the investigator, but he later declined to speak to us.

12. NHS England commissioned a clinical reviewer to review Mr Dawes-Clarke's clinical care at the prison. The investigator and clinical reviewer visited Elmley on 8 December 2021. They obtained copies of relevant extracts from Mr Dawes-Clarke's prison and medical records, viewed CCTV and body worn video camera (BWVC) footage and listened to Mr Dawes-Clarke's prison telephone calls. The investigator also obtained a copy of the HMPPS Early Learning Review.

13. We suspended our investigation in December 2021, pending the outcome of a police investigation. We resumed it in November 2023, when Kent Police told us that no criminal charges would be brought. The original investigator no longer works for the PPO, so a new investigator was assigned to investigate Mr Dawes-Clarke's death.

14. The investigator obtained copies of the Southeast Coast Ambulance Service (SECAmb) records (including four separate incident reports submitted after Mr Dawes-Clarke died), Mr Dawes-Clarke's hospital record for 8 November 2021, an Internal Investigation Complaint Report by SECAmb following concerns raised about attending paramedics (made by the Deputy Governor at Elmley), Kent Police's Evidence Review Report and their report to the Coroner.

15. The investigator and clinical reviewer interviewed 22 members of staff in January and February 2023. We attempted to interview three other members of staff; a mental health nurse, the healthcare assistant that discovered Mr Dawes-Clarke on 10 November and the prison Imam, but they were not currently working at the prison and did not respond to our approaches.

16. We informed HM Coroner for Mid-Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Dawes-Clarke's mother to ask if she had any matters she wanted us to consider. Mr Dawes Clarke's mother said that she did not believe that her son had killed himself. She later appointed a legal representative, and they asked the investigation to consider the following questions:

    - Was Mr Dawes-Clarke known to be suicidal?
    - Did someone phone Mr Dawes-Clarke to tell him his sister had been involved in a serious car accident?
    - How did Mr Dawes-Clarke acquire two chair legs to assist his self-harm as the prison have said?
    - Why only part of the incident that led to Mr Dawes-Clarke being restrained was captured on body-worn footage?

18. Mr Dawes-Clarke's family received a copy of the initial report. On 19 September 2024, the PPO's assistant ombudsman, investigator and family liaison officer met with Mr Dawes-Clarke's family and their legal representative to explain the investigation remit and answer any immediate questions. Mr Dawes-Clarke's family did not identify any factual inaccuracies. However, via their legal representative, they raised several issues for the PPO to consider before issuing their final report. We have considered these submissions carefully and have made some amendments to the final report as a result. Mr Dawes-Clarke's family also asked questions that have been answered in a separate correspondence.

19. Mr Dawes-Clarke's family asked for the Control & Restraint Instructor to be removed from her role, pending the outcome of a review by the National Incident Management Unit, and for disciplinary action to be considered by the Governor. The PPO shared this request with the Governor. We provided Mr Dawes-Clarke's family and legal representative with the prison's response.

20. We also shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies (although corrected the spelling of the Governor's surname).

21. Neither HMPPS nor the PPO received a response from SECAmb in response to our recommendation.

Background Information

HMP Elmley

22. HMP Elmley, located on the Isle of Sheppey, holds men who are remanded and sentenced in six houseblocks with a mixture of single, double and triple cells. In November 2021, when Mr Dawes-Clarke was at Elmley, IC24 provided healthcare services. Since April 2022, Oxleas NHS Foundation Trust has provided healthcare services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Elmley was in March 2022. Inspectors reported that staff and prisoner relationships were better than in comparable prisons. However, use of force had gone up significantly and leaders had not done enough to understand the reasons for this rise. Inspectors were concerned that a much larger number of use of force incidents than they usually see were routinely being classed as "miscellaneous" rather than being put in a more suitable category. Segregation to manage the most challenging prisoners was used proportionately. Use of force documentation was not always fully completed and, although body-worn video cameras were readily available, too many staff failed to activate them during an incident to provide evidence and support de-escalation. They made a recommendation to the Governor that staff routinely switch on body-worn cameras during use of force incidents.

24. Inspectors noted that the safer custody team was well resourced and had recently introduced some good initiatives and safeguards to identify and support prisoners at risk. Prisoners supported through ACCT case management were generally positive about the care they received, although there were some weaknesses in the process itself. There was an action plan to improve the quality of case management.

25. Inspectors found that against a background of significant workforce challenges, mental health services had responded positively to prisoners in need of urgent support. Prisoners waited longer than before the COVID-19 pandemic to access routine psychological care, but caring staff provided alternative support while they waited.

26. Inspectors returned to Elmley in February 2023, to undertake an Independent Review of Progress. They identified that Elmley still had substantial staff shortages. However, they noted that the use of body-worn cameras during use of force incidents was now at 95%, far greater than at other prisons, and was described as excellent. Managers were now routinely using footage to improve de-escalation and highlight good practice.

Independent Monitoring Board

27. 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 published annual report, for the year to 31 October 2022, the IMB reported that weekly use of force scrutiny ensured that restraint was used

appropriately and safely. They found that use of body worn cameras was more effective, evidencing the need for force and creating confidence in the system.

28. The IMB noted that the introduction of quality assuring ACCT entries had led to improved care plans. However, they agreed with HMIP inspectors that not enough was being done to understand and address the underlying causes of self-harm.

29. The IMB reported that black prisoners were overrepresented in the segregation unit, with 18% of the segregation population being black, against an overall population of 11%.

Previous deaths at HMP Elmley

30. Mr Dawes-Clarke was the sixteenth prisoner to die at Elmley since November 2018. Eleven of these deaths were due to natural causes, two were self-inflicted and two were due to illicit drug use. To the end of June 2023, there have been five deaths due to natural causes, two self-inflicted deaths and one awaiting classification.

31. In November 2023, a black prisoner located in the healthcare inpatient unit also died following restraint. His cause of death was cocaine toxicity, and he had an underlying heart condition, but the pathologist concluded that this, along with exertion during the restraint, was a contributory factor in his death. Kent Police have not identified any criminal offences.

Assessment, Care in Custody and Teamwork

32. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

33. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Alternative clothing

34. Alternative clothing is special clothing made from material which is extremely difficult to tear into strips to create ligatures. Prison Service Instruction (PSI) 64/2011 instructs that it must only be used as a last resort and that consideration must be given to whether alternative options (such as placing the prisoner in a safer cell with reduced ligature points) would be sufficient to mitigate risk. The decision to use alternative clothing should take into consideration the potential impact it may have on the prisoner as it is considered dehumanising. If alternative clothing is used then an urgent ACCT case review must be held, with case review teams considering any impact on risk and identifying how this can be mitigated through support actions, with a view to ending its use.

Special accommodation

35. Special accommodation is a dedicated cell or improvised normal accommodation with anyone (or more than one) of the following items removed in the interests of safety: furniture, bedding, sanitation. Special accommodation should only be used for the shortest necessary time, to prevent a violent or refractory prisoner injuring themselves or others, damaging property or creating a disturbance. The prisoner should be informed of the reasons why and anyone being held in special accommodation must be observed by staff at least five times per hour, at irregular intervals. Prison Service Order 1700, Chapter 7, clearly states that the duty governor (or Governor) must give authority before a prisoner is located in special accommodation.

Key Events

36. On 8 June 2018, Mr Azroy Dawes-Clarke was sentenced to 51 months imprisonment for robbery. He had been to prison before. Mr Dawes-Clarke was released from HMP High Down on 27 March 2020, but recalled on 23 April for committing further offences and breaching his licence. He was taken to HMP Elmley. On 2 June 2021, Mr Dawes-Clarke was sentenced to seven years and nine months for robbery.

37. Mr Dawes-Clarke had a diagnosis of Behçet's syndrome, an inflammatory disorder which affects multiple parts of the body, including causing painful sores in the mouth and inflammation of parts of the eye. This condition is uncommon but not life-threatening and he was prescribed a range of medications and was seen by NHS specialists. He also had moderate chronic kidney disease, which required lifestyle measures and medication.

38. Mr Dawes-Clarke had a diagnosis of personality disorder. He frequently articulated that this was the reason for his challenging behaviour. He was referred to psychology services on several occasions but did not always engage in the work. Mr Dawes-Clarke had been identified as being suitable for a trial of ADHD medication, he took this for a short period only and stopped at his own request. Although Mr Dawes-Clarke said he had a diagnosis of Autistic Spectrum Disorder, there is nothing to support this diagnosis in his medical records.

39. Mr Dawes-Clarke was also diagnosed with depression and at times struggled with his mental health. He was prescribed an antidepressant (mirtazapine). Mr Dawes-Clarke also had a long history of self-harm and suicidal behaviour in prison dating back to 2010. In total, between June 2010 and July 2021, Mr Dawes-Clarke was supported by ACCT procedures on at least 35 occasions, following threats to take his own life, low mood, cutting, and being found with tied ligatures (which, on several occasions, led to a loss of consciousness). His prison record details that Mr Dawes-Clarke's self-harming behaviour was associated with times when he felt he was being treated unfairly and as a means of manipulating his situation. Prison staff also recorded that Mr Dawes-Clarke was unable to appropriately manage his emotions. He told staff that he used self-harm and tying ligatures to express his emotional turmoil.

40. During his time at Elmley, Mr Dawes-Clarke was subject to COVID-19 restrictions, along with other prisoners, to help stop the spread of the virus. He often complained about how his physical health was being managed, which often resulted in him self-harming or tying ligatures and being supported via ACCT procedures.

41. In the months before he died, Mr Dawes-Clarke had regular key work sessions and met with his Prison Offender Manager (POM). In June 2021, Mr Dawes-Clarke asked to transfer to HMP Dovegate (which has a therapeutic community to support reducing risk and offending) and his POM helped him complete an application form. However, on 5 July, Dovegate informed Mr Dawes-Clarke that he did not meet their criteria.

42. Over the following weeks, staff recorded that Mr Dawes-Clarke was complying with the wing regime and that his behaviour had improved. He received positive reports

from his job in the food packaging workshop and from houseblock staff. Although he received some negative reports for poor behaviour, Mr Dawes-Clarke had not been involved in any violent incidents since he had returned to Elmley in April 2020.

43. On 17 September, Mr Dawes-Clarke was sacked from his job as he chose to attend the gym instead of working. In the following month, he received two negative entries for returning very slowly to his cell after collecting his medication.

Events from 25 October 2021

44. At around 9.40am on 25 October, Mr Dawes-Clarke was let out of his cell to collect his medications, but despite being asked several times to return to his cell he refused. Mr Dawes-Clarke then began to walk towards his cell. CCTV shows him walking down the stairs on Houseblock 4, accompanied by five officers. Mr Dawes-Clarke appears to be walking very slowly and is being encouraged to walk faster. When he reached the landing and was away from the stairs, Officer A initiated force; she jumped on Mr Dawes-Clarke's back, with her arms around his neck, before her colleagues used control and restraint (C&R) techniques to take him to the floor. CCTV shows that Mr Dawes-Clarke did not offer any resistance, although staff said in their statements that he was 'passively resisting'. In her use of force statement, the officer said, 'I am well aware of Mr Dawes-Clarke's behaviour everyday giving staff issues with his meds. He consistently avoids staff banging him up (returning him to his cell) and resists against the regime'. She recorded that after another officer had tried to de-escalate the situation, she placed her hand on Mr Dawes-Clarke's back to guide him, but his demeanour became more aggressive as he did not want to be touched. She described Mr Dawes-Clarke pushing back on her and that he said, 'what are you going to do about it?'. She recorded that she initiated restraint due to his continued passive resistance and because she was unsure what his next actions would be.

45. Officers took Mr Dawes-Clarke to the segregation unit. He walked to the unit and was compliant throughout. Staff charged Mr Dawes-Clarke with an offence of using threatening, abusive or insulting words or behaviour and disobeying a lawful order. (These charges were not proceeded with because staff had not issued the documentation to Mr Dawes-Clarke within 48 hours of the alleged offence being committed.)

46. Soon after arriving in the segregation unit, staff found Mr Dawes-Clarke lying on his bed in his cell and choking with a ligature tied around his neck. He stated that he did not want to live and was upset at being in the segregation unit as he believed he had done nothing wrong. Staff started ACCT procedures and implemented an immediate care plan. Shortly afterwards, Mr Dawes-Clarke tied another ligature. Staff observed Mr Dawes-Clarke five times an hour until he could be fully assessed and placed him in alternative clothing (a gown made from material that is very hard to tear).

47. A nurse assessed that Mr Dawes-Clarke was not medically fit to remain segregated. Staff therefore took Mr Dawes-Clarke to the healthcare inpatient unit (IPD) and allocated him a safer cell (these are specially designed to have minimal ligature points). The only source of support noted on his ACCT was Mr Dawes-Clarke's mother, but he said that he did not want his mother informed.

48. At 1.00pm, an officer completed Mr Dawes-Clarke's initial ACCT assessment. Mr Dawes-Clarke reported feeling anxious about issues outside of prison and that staff did not understand his mood swings. He said that he had a long history of self-harm, which was connected to his mental health and stress. Mr Dawes-Clarke said that he often acted impulsively without thinking of the consequences but that his actions after he had been restrained were a genuine suicide attempt. He told the officer that he wanted to move back to Houseblock 4, so that he had his usual distractions and access to the telephone to call his family for support (a review of Mr Dawes-Clarke's telephone records show that he kept in contact with his family while at Elmley).

49. At 1.25pm, the IPD manager chaired the first ACCT case review. A mental health nurse, an officer, a Custodial Manager (CM) and Mr Dawes-Clarke attended. Mr Dawes-Clarke said he wanted to return to Houseblock 4 as he thought he would be able to manage his mood better and did not want to remain in the IPD. The IPD manager recorded that the panel considered it was in Mr Dawes-Clarke's best interests to return to the houseblock where he would have his possessions, access to a phone and TV, but explained to him that he had been charged with a disciplinary offence for the incident earlier in the day and would have to remain behind his cell door, which Mr Dawes-Clarke accepted. They encouraged Mr Dawes-Clarke to speak to staff if he needed support. The panel agreed to reduce the frequency of ACCT observations to a minimum of one per hour. Two support actions were recorded; Mr Dawes-Clarke to return to Houseblock 4 and for the mental health in-reach team (MHIT) to attend the next review. The next ACCT review was scheduled for 1 November.

50. After the ACCT review, the nurse incorrectly recorded in Mr Dawes-Clarke's medical record that he was on constant supervision. She also recorded that he had tied a ligature while in the IPD and had briefly barricaded his cell with a mattress. (This information was not recorded elsewhere, and we do not know whether it was accurate.) Later that afternoon, Mr Dawes-Clarke was moved back to Houseblock 4 and was given his own clothes back.

51. On 26 October, the multi-disciplinary mental health team meeting discussed Mr Dawes-Clarke. They agreed that he would be referred to Bradley Therapy Services (for talking therapy) and that healthcare staff would attend all ACCT reviews. They added Mr Dawes-Clarke to their caseload for two to three weeks for ongoing observation and assessment.

52. On 28 October, an officer recorded that Mr Dawes-Clarkes had covered his observation panel and refused to collect his medication. As a result, a wing manager downgraded him to the basic IEP level. (IEP is a three-tier system designed to encourage and reward good behaviour in prison.)

53. On 1 November, a Supervising Officer (SO) chaired an ACCT review, attended by a prison chaplain and Mr Dawes-Clarke. Although not recorded on the ACCT document, a mental health nurse noted in Mr Dawes-Clarke's medical record that she also attended the review. The SO recorded that Mr Dawes-Clarke engaged well, and although still annoyed that he had been restrained, he was more settled having spoken to the mental health team and the chaplain. Mr Dawes-Clarke said he had no thoughts of suicide or self-harm. The SO noted that both support actions had been completed and did not add any new actions. The panel reduced the

frequency of ACCT observations to hourly during the night and one conversation per day. The next ACCT review was scheduled for 11 November.

54. On 6 November, the SO chaired an ACCT review, attended by the Head of Reducing Reoffending and Mr Dawes-Clarke. Nobody from the healthcare team attended. The review was held because Mr Dawes-Clarke told the SO that he had received bad news and that his sister had been in a car accident which resulted in her having her legs amputated. (This information was not correct. We do not know how Mr Dawes-Clarke received this news, but it is what he told prison and healthcare staff.) The SO recorded that Mr Dawes-Clarke was extremely upset, worried, and agitated. He told Mr Dawes-Clarke that he would request for him to have a telephone call with his brother who was at HMP Wakefield, but this was not likely to be until the following week.

55. Mr Dawes-Clarke said he did not have current thoughts of suicide or self-harm, but that they were always in the background. The panel increased ACCT observations to a minimum of one per hour during patrol state (when prisoners are locked in their cells and there is a reduced level of staffing) and during the night. In addition, staff were required to have two quality conversations with Mr Dawes-Clarke each morning and afternoon. No support actions were added. The SO scheduled the next review for 8 November.

56. On 7 November, wing staff asked healthcare staff to examine Mr Dawes-Clarke as he said he had sickness and diarrhoea. The clinical manager for the IPD examined him and noted his clinical observations were all within in the normal range but that Mr Dawes-Clarke was anxious and concerned about his kidney issues. She advised him to drink plenty of fluids.

57. In the early hours of 8 November, Mr Dawes-Clarke told wing staff that he was still unwell. The emergency response nurse examined him in his cell and noted that Mr Dawes-Clarke was vomiting and said he had been unwell for two days. Mr Dawes-Clarke said that he had not passed urine in that time and was now unable to. She sent Mr Dawes-Clarke to hospital.

58. At 2.50am, an ambulance took Mr Dawes-Clarke to Medway Hospital. He was escorted by two officers, and restraints were applied. After a hospital doctor decided to discharge Mr Dawes-Clarke back to Elmley without antibiotics, which he believed he should have but were not clinically required, Mr Dawes-Clarke became agitated and threatened to punch the doctor. The escorting officers returned him to Elmley.

59. Between 29 October and 9 November, Mr Dawes-Clarke made nine telephone calls, which the investigator listened to. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.) These calls were mostly to his mother, but he also spoke to his sister (we do not know if this is the sister he thought had been in an accident) and a friend. The calls to his mother and sister were general conversations. The last call Mr Dawes-Clarke made was to his friend at 9.48am on 9 November. He sounded out of breath and told his friend not to take any calls if someone rang and said that someone he knew had been beaten up. His friend did not appear to understand what Mr Dawes-Clarke was talking about. Mr Dawes-Clarke ended the call after one minute.

60. At 2.30pm, a CM chaired an ACCT review, attended by a mental health nurse, a substance misuse worker, a prison chaplain and Mr Dawes-Clarke. The CM recorded that Mr Dawes-Clarke said that he was upset about his sister, that he had a personality disorder and that being segregated had triggered a panic attack. Mr Dawes-Clarke disclosed that he used self-harm as a means of stress relief but was finding contact with the mental health team helpful. Mr Dawes-Clarke told the review that he did not want to be on Houseblock 4 but understood that due to non-association markers with other prisoners at Elmley (because of issues that Mr Dawes-Clarke was understood to have with some individuals in the community) he was not able to move to another houseblock. The panel agreed that the number of observations and conversations should remain the same. No support actions were recorded. The next review was scheduled for 10 November.

Events of 9 November

61. On 9 November at 12.45pm, during a routine ACCT observation, an officer discovered that Mr Dawes-Clarke had barricaded his cell door and tied a ligature around his neck. He radioed a code blue medical emergency code (used when a prisoner is unconscious or has breathing difficulties). Body Worn Video Camera (BWVC) footage shows he persuaded Mr Dawes-Clarke to remove the ligature (a sock) and spoke to him through the cell door. A SO responded to the code blue and went to Mr Dawes-Clarke's cell. A general nurse also responded and when Mr Dawes-Clarke removed the furniture he had placed behind his door, staff entered. Mr Dawes-Clarke told them he had tied the ligature as he believed people were trying to get into his cell to attack and kill him. He said he wanted to be moved and if he was not moved from the houseblock he would continue to tie ligatures. During the conversation, officers observed that Mr Dawes-Clarke had broken metal chair legs (from the chair in his cell), hidden in his trousers, which they removed. Mr Dawes-Clarke explained that these were for his own protection.

62. Staff removed Mr Dawes-Clarke's clothing to mitigate the risk of further ligature and gave him alternative clothing. There is no record that this was authorised by an operational manager. There was no space in the IPD, so staff allocated Mr Dawes-Clarke a safer cell on Houseblock 1 over the lunch period, until a space became available in the IPD. They removed the mattress from the cell so that Mr Dawes-Clarke could not tear the cover to create a ligature. The SO increased the frequency of ACCT observations to a minimum of once every half an hour.

63. After lunch, staff moved Mr Dawes-Clarke to what is usually a constant supervision cell in the IPD. (A constant supervision cell has fewer ligature points than a standard prison cell. It also has a barred gate which can be used instead of a standard cell door, although for Mr Dawes-Clarke the standard cell door was used.) Mr Dawes-Clarke's cell contained a bed, mattress and pillow, but there was no other furniture and no bedding, so it amounted to special accommodation. Again, this was not authorised by an operational manager and Mr Dawes-Clarke was not observed five times per hour in line with national policy on the use of special accommodation.

64. At 3.30pm, a CM chaired an ACCT review, which was attended by a nurse, the SO, two officers and Mr Dawes-Clarke. They recorded that Mr Dawes-Clarke's mental health appeared to have deteriorated; he was paranoid and convinced other

prisoners were intent on harming him. Mr Dawes-Clarke said he wanted to be transferred to another prison. The CM did not record if the review panel thought Mr Dawes-Clarke was at high risk of suicide or self-harm or why he should remain in a constant supervision cell when he was not subject to constant supervision (although his risk was deemed high enough for him to remain in alternative clothing). The CM did note that a mental health nurse should attend the next review. The review panel agreed Mr Dawes-Clarke should remain on 30-minute observations until his next review, which was scheduled for 11 November. No support actions were added.

65. There are no entries in Mr Dawes-Clarke's ACCT detailing a summary of the events in the afternoon, or if staff had any meaningful conversations with him in the evening. Staff recorded that they completed observations twice an hour.

Events of 10 November

66. Mr Dawes-Clarke was meant to be observed twice an hour until his next scheduled ACCT review. However, the ACCT ongoing record had been amended on 10 November, to show that he should be observed hourly while in patrol state, with two conversations in the morning and afternoon. We do not know who made this entry, but despite this, staff continued to record observations twice an hour. There was no written summary from night staff.

67. An officer recorded in Mr Dawes-Clarke's ACCT that during the morning he had pressed his cell bell several times and told staff that he was not getting help for kidney failure. Officers described him as acting bizarrely and making strange comments.

68. A nurse told us that healthcare staff were concerned about Mr Dawes-Clarke's behaviour as his mental health appeared to be deteriorating. They therefore asked a psychiatrist at Elmley to assess him. Sometime between 11.00am and 12.00pm, the psychiatrist visited Mr Dawes-Clarke. She recorded that Mr Dawes-Clarke said he felt better having been moved to the IPD and that he wanted to see the Imam. Mr Dawes-Clarke told her that he felt paranoid that other prisoners and staff were against him but denied having any auditory or visual hallucinations. Mr Dawes-Clarke said that the news about his sister being in an accident had affected his emotions.

69. The psychiatrist noted that Mr Dawes-Clarke's speech was coherent but that his mental state had deteriorated acutely within the past 24-48 hours. She concluded that there was no sign of psychosis. She assessed that Mr Dawes-Clarke's risk of suicide or self-harm was elevated, that he was aware he was being supported by ACCT procedures and that he should remain in the IPD for a period of assessment. She prescribed an antipsychotic (olanzapine) to be taken at night, but this was not administered to Mr Dawes-Clarke before he died.

70. There is no record in the ACCT document, medical record, or elsewhere of any staff interaction with Mr Dawes-Clarke during the afternoon, other than routine completion of his ACCT observations.

71. The investigator watched the available body worn video camera (BWVC) footage and listened to prison radio transmissions from 10 November. She also obtained information from the Southeast Coast Ambulance Service (SECAmb). The following

account has been taken from all sources. There is no closed-circuit television covering the corridor where Mr Dawes-Clarke's cell was located.

72. At 4.25pm, an officer completed an ACCT observation and noted that there were no concerns. Around five minutes later, he gave Mr Dawes-Clarke his dinner.

73. At 4.40pm Mr Dawes-Clarke pressed his cell bell. A healthcare assistant (HCA) responded and found him lying on the floor with a ligature around his neck. She shouted for help from nearby staff; she did not call a code blue and she did not stay with Mr Dawes-Clarke, instead going to get officers from elsewhere on the unit. Two officers responded, cut the ligature and radioed a code blue medical emergency. (The police confirmed that the ligature was made from strips of material from Mr Dawes-Clarke's pillow, rather than from his mattress cover as some staff believed.)

74. The control room operator requested an ambulance. The investigator and lead clinical reviewer listened to the recorded telephone conversations between the control room and the Ambulance Service. When the request was originally made for an ambulance, prison staff stated it was a 'code blue situation'. This appeared to mean nothing to the ambulance call handler and the prison control room were unable to provide any details about Mr Dawes-Clarke's medical situation. The ambulance service called back but were unable to speak to anyone who could provide any clinical information about the emergency. Finally, there was a call by the prison requesting an update on the estimated arrival time (ETA) of the second ambulance. Although the reference for the first call was available, it did not help the ambulance service to identify that this was not a new request, and no ETA was ever given.

75. The officers in Mr Dawes-Clarke's cell observed that he was struggling for breath, thrashing around, and moving on the floor in an uncontrolled manner. Healthcare staff responded to the code blue and a nurse and the then Head of Healthcare attended. Staff moved Mr Dawes-Clarke from lying on his front to his back and they assessed him. His oxygen saturation was low but quickly improved when he was given oxygen. Staff were requested to collect emergency equipment.

76. The nurse said that they attached the pads for a defibrillator to Mr Dawes-Clarke's chest, although he had a pulse and was breathing. She tried to record his blood pressure, but he was moving around on the floor and could not stay still. She noticed he had blood coming from his mouth and thought he may have bitten his tongue.

77. At around 4.50pm, the then Head of Healthcare asked two GPs at Elmley to assess Mr Dawes-Clarke, as she had serious concerns about him. Both doctors concluded he was experiencing seizures, which were continuing. They decided to administer 10mg of rectal diazepam, followed by a further 10mg of rectal diazepam when the first dose had no effect. Mr Dawes-Clarke continued fitting so they administered 7.5mg of diazepam by injection. (The medical notes do not make clear who administered the diazepam.) Around five minutes after the third dose of diazepam was administered, Mr Dawes-Clarke stopped shaking and his muscles and breathing became more relaxed, but he was still not speaking. The timeframe for administering the diazepam was estimated to be between 20 – 40 minutes.

78. At 5.34pm, paramedics arrived at Elmley. (The location of Elmley, availability of ambulances, and roadworks, all delayed paramedics.) The two prison doctors provided them with a handover and left the prison. (The nurse and the then Head of Healthcare had also left the scene at some point.) Paramedics recorded that they did not observe any marks around Mr Dawes-Clarke's neck, that his oxygen level was good and that there were no concerns about his airway. They established his level of consciousness as 14, using the Glasgow Coma Scale (GCS - an objective method to determine the conscious state of a patient. Three types of response are measured (eye, verbal and motor), and are added together to give an overall score. The lower the score, the lower the patient's conscious state. The maximum score is 15, showing that the patient is alert, responsive and breathing. Three is the lowest score, showing no responses). The paramedics noted that Mr Dawes-Clarke did not spontaneously open his eyes.

79. When one of the paramedics tried to place a blood pressure cuff on Mr Dawes-Clarke's arm he was noted to have resisted and pulled his arm away. The paramedic recorded that Mr Dawes-Clarke was smirking. Paramedics had concerns about the level of diazepam that had been administered to Mr Dawes-Clarke and wanted to speak to the prison doctors, but they had already left the establishment.

80. The paramedics decided that Mr Dawes-Clarke should be taken to hospital. One paramedic went to get a stretcher from the ambulance, while another tried to insert an oral airway, despite Mr Dawes-Clarke being assessed as fully conscious and there had been no change in his condition. This was unsuccessful as was an attempt to insert a nasal airway. Mr Dawes-Clarke was noted to have violently waved his arms around and no further attempts were made to insert an airway. Because he had no clothing on, except the alternative clothing, prison staff and paramedics agreed that, for his dignity, it would be appropriate to try and put some clothes on Mr Dawes-Clarke's lower half.

81. At around 6.00pm, two officers attempted to put some boxer shorts on Mr Dawes-Clarke. They recorded that Mr Dawes-Clarke scratched one officer and kicked the other. A paramedic also recorded that Mr Dawes-Clarke kicked them (and so the paramedic left the cell). An officer initiated a restraint to control Mr Dawes-Clarke and, together with another officer, was joined by four further prison officers who took part in the restraint. Staff requested assistance from the duty prison manager as they had initiated a restraint and needed a set of handcuffs. Prison healthcare staff did not attend.

82. At 6.07pm, seven minutes after they were asked for assistance, the duty prison manager and a CM (the assistant duty manager) arrived at the incident and activated their BWVCs. Footage indicates that the assistant duty manager at least did not appear to hurry to the incident. Two other staff also responded. BWVC footage shows three paramedics standing in the corridor outside of Mr Dawes-Clarke's cell.

83. BWVC footage shows Mr Dawes-Clarke lying still and passively on his back on the floor, restrained by five officers; an officer did not have hands on Mr Dawes-Clarke at this point. Mr Dawes-Clarke can be heard making grunting noises, but he did not speak or make any threats.

84. The duty manager decided that Mr Dawes-Clarke should be handcuffed and as there were no Elmley healthcare staff present, the assistant duty manager asked paramedics waiting outside of the cell if they had any objections to restraints being applied. They replied that they did not.

85. At 6.09pm, Officer B observed that Mr Dawes-Clarke's eyes were bulging. The duty manager replied that perhaps Mr Dawes-Clarke was in medical distress rather than being non-compliant.

86. At 6.10pm, Officer B encouraged Mr Dawes-Clarke to sit up and asked if he could breathe okay. The assistant duty manager asked who had been supporting Mr Dawes-Clarke's head during the restraint (known as the number one position) and Officer B replied, 'Nobody by the look of it'. The officers raised Mr Dawes-Clarke into a sitting position and the assistant duty manager applied handcuffs to Mr Dawes-Clarke's wrists, behind his back. Mr Dawes-Clarke made no sound. Staff lifted Mr Dawes-Clarke to sit him on the bed, but he became floppy and unresponsive. The assistant duty manager instructed staff to put Mr Dawes-Clarke on the floor, in the recovery position, for him to be assessed.

87. At 6.11pm, the assistant duty manager removed the handcuffs, still clearly unsure if Mr Dawes-Clarke was genuinely unwell or pretending. An officer checked Mr Dawes-Clarke for a pulse but did not confirm if he found one. Because there were no prison healthcare staff present, the assistant duty manager instructed staff to activate the general alarm so that healthcare staff would attend. At the time, Mr Dawes-Clarke was laid on the floor, not fully in the recovery position. (The paramedics were still standing outside the cell door, looking in. The assistant duty manager told us that he was surprised by their reluctance to come into the cell and assist.)

88. At 6.12pm, the assistant duty manager asked a nurse, who had just arrived in response to the general alarm, whether they could confirm if Mr Dawes-Clarke was genuinely unwell or pretending. He added that Mr Dawes-Clarke had a 'violent tendency'. He suggested again that Mr Dawes-Clarke might be pretending to be unwell or might not be breathing.

89. Officer B then confirmed that he could not feel a pulse. At 6.13pm, the nurse recognised that Mr Dawes-Clarke was in cardiac arrest and started cardiopulmonary resuscitation (CPR). (This was around four minutes and 21 seconds after the last definite sound was heard from Mr Dawes-Clarke.) Paramedics also now entered the cell and began providing urgent care to Mr Dawes-Clarke. He remained in cardiac arrest for approximately 12 minutes before a heartbeat was detected. We were told that a defibrillator had been attached earlier, but it was not attached when Mr Dawes-Clarke became unresponsive and without BWVC footage, we do not know when or why it was removed, or if indeed it had been attached.

90. At 6.33pm, a paramedic confirmed that Mr Dawes-Clarke had a pulse. At 6.40pm, a paramedic said to the nurse that he thought the prison GP had given Mr Dawes-Clarke too much diazepam.

91. At 6.41pm, additional paramedics arrived at the cell. During a handover between paramedics, they said that they had to use the prison defibrillator, as the ambulance

crew did not have the correct pads for their machine. At 6.53pm, Mr Dawes-Clarke was placed on a stretcher and taken to the ambulance.

92. On the journey to hospital, Mr Dawes-Clarke went into cardiac arrest and the ambulance stopped to provide emergency care. He was stabilised and they continued their journey, arriving at Medway Hospital at around 7.40pm. Despite continued efforts, Mr Dawes-Clarke was declared dead at 8.13pm.

93. The investigator was given a copy of a letter that was found in Mr Dawes-Clarke's cell. We do not know when he wrote this. The letter was addressed to Mr Dawes-Clarke's mother. He wrote that everything he said on the phone was a lie, and that Elmley had nothing to do with his death. Mr Dawes-Clarke wrote that the reason he killed himself was because of his medical conditions, the pain he was in and because of all the hospital appointments. Mr Dawes-Clarke's family told us that they do not think that he wrote this letter, based on the handwriting and the language used.

94. Kent Police investigated the circumstances surrounding the restraint but concluded that no criminal offence had been committed.

Contact with Mr Dawes-Clarke's family

95. The prison appointed a family liaison officer (FLO) and a deputy. At 7.55pm, the FLO phoned Mr Dawes-Clarke's mother to inform her that he had been taken to Medway Hospital. She declined the offer of a taxi to take her directly to the hospital. At 8.15pm, the FLO phoned Mr Dawes-Clarke's mother to inform her that he had died. The prison offered ongoing support and to contribute towards the costs of Mr Dawes-Clarke's funeral, in line with national instructions.

Support for prisoners and staff

96. After Mr Dawes-Clarke's death, the then Governor debriefed some of the prison 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. Healthcare staff said that they were not offered immediate support and did not attend any formal debrief.

97. There was no collective debrief with all the staff involved. One of the officers who escorted Mr Dawes-Clarke to hospital said he was expected to report for duty early the next morning, despite leaving the prison not long before midnight. Most staff said the incident was never formerly discussed with them by managers.

98. The response nurse told us he went home after the incident and that he never had an opportunity to have a reflective discussion with those involved. The psychiatrist who had assessed Mr Dawes-Clarke on 10 November, found out he had died via a general email, some days later, and she had to telephone colleagues at Elmley to find out what had happened.

99. The prison posted notices informing other prisoners of Mr Dawes-Clarke's death and offering support. Staff reviewed all prisoners assessed as being at risk of

suicide or self-harm in case they had been adversely affected by Mr Dawes-Clarke's death.

Post-mortem report

100. The post-mortem recorded that Mr Dawes-Clarke's death was due to a hypoxic ischaemic brain injury (caused by a lack of oxygen), due to cardio-respiratory arrest in close temporal proximity (events that occurred relatively close together) to a period of third party restraint, shortly after apparent seizure like activity treated with diazepam following compression of the neck by a ligature.

101. The pathologist was unable to conclude whether Mr Dawes-Clarke had already sustained significant, irreversible, hypoxic ischaemic damage to his brain at the point the ligature was removed. The pathologist found no evidence of surface or deep bruising to support that the staff involved in the restraint had used severe or inappropriate force. The pathologist concluded that the cause of death was multifactorial and could not identify any single event as being the main cause.

102. Toxicology results detected only prescribed medication.

Findings

Managing the risk suicide and self-harm

103. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), contains requirements for staff using ACCT procedures. Staff are required to use ACCT when they identify that a prisoner is at risk of suicide and self-harm, based on identified risk factors and triggers. The PSI says that ACCT case reviews should be multidisciplinary where possible, that a support plan should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. Support actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time-bound.

104. During his time in custody, Mr Dawes-Clarke had often been supported using ACCT procedures. He had several risk factors that increased his risk of suicide and self-harm, including a recent and escalating history of tying ligatures and self-strangulation. Mr Dawes-Clarke had harmed himself several times in prison through various means and was being treated for depression. In the time before his death, he (incorrectly) believed that his sister had been involved in a serious accident.

105. Staff appropriately started ACCT procedures on 25 October 2021, after Mr Dawes-Clarke tied a ligature around his neck, and he was still being monitored at the time of his death. However, we are concerned that the procedures were very poorly managed and did little to support Mr Dawes-Clarke. We cannot say whether this would have affected the eventual outcome for Mr Dawes-Clarke, but it might have helped prison staff identify his risk and produce an effective care plan, aimed at addressing his issues and reducing his risk.

106. PSI 64/2011 states that during case reviews, the case review team must set and review support actions to mitigate risk. Support actions could have been set to address issues that affected Mr Dawes-Clarke's risk, including his mental health, impulsive behaviour, and his concerns about his physical health. Support actions could also have played an important role in helping Mr Dawes-Clarke to contact his family to help him understand what, if anything, had happened to his sister, which was a significant trigger for his distress. Towards the end of his life, support actions could have been used to help plan how Mr Dawes-Clarke's risk could be managed to allow him to wear his own clothes or return to a standard prison wing. Two support actions were set at the first review and noted as completed at the second review. However, between 1 November and 10 November, no other support actions were set during the case reviews, despite Mr Dawes-Clarke's increasingly risky behaviour and attempts to self-strangulate.

107. Case reviews are also required to set appropriate levels of observations and conversations. During his ACCT assessment, Mr Dawes-Clarke said that he had intended to kill himself when he tied a ligature in the segregation unit. Despite the first case review being just two hours after this suicide attempt, the review reduced the ACCT observations to one per hour as Mr Dawes-Clarke said he would not self-harm if he moved back to Houseblock 4. Given that Mr Dawes-Clarke had very recently attempted to take his life, we do not think that this was an appropriate assessment of his risk, and observations should have been more frequent.

108. On 9 November, Mr Dawes-Clarke barricaded his cell and tied a ligature around his neck, which he said that he did to end his life. Staff increased the frequency of observations to a minimum of one every half an hour.

109. In the time before he self-strangulated on 10 November, Mr Dawes-Clarke presented with indicators of increased risk. He had been described as acting bizarrely and constantly using his cell bell. The prison psychiatrist who had seen him in the morning, had concerns that Mr Dawes-Clarke showed signs of developing mental illness, requiring a period of observation and assessment in the IPD and was at elevated risk of suicide. No one recognised that these factors might indicate that his risk of suicide had increased, and that the frequency of observations should be increased.

110. PSI 64/2011 gives examples of when staff should consider placing prisoners under constant supervision. These include serious attempts and/or compelling preparations for suicide, or a recent and credible attempt by a prisoner to take their own life. Given Mr Dawes-Clarke's behaviour on 9-10 November, staff should have considered whether he needed to be constantly supervised and documented this decision. As a minimum, they should have considered whether two observations per hour was appropriate to Mr Dawes-Clarke's current circumstances.

Alternative clothing and special accommodation

111. Prison Service Order (PSO) 1700, regarding segregation, defines special accommodation as a cell in which one or more of furniture, bedding or sanitation is removed in the interests of safety, to prevent a violent or refractory prisoner from injuring others, damaging property or creating a disturbance. It states that special accommodation should be used for the shortest time possible and must be authorised by the duty operational manager. A record must be kept of the reasons for the decision, which should be reviewed hourly. Healthcare staff must complete a health screen to determine if there are any clinical reasons against using special accommodation. Prisoners being held in special accommodation must be observed at least five times per hour.

112. PSI 64/2011 says that alternative clothing must only be used as a last resort. Case review teams must consider through support actions how to mitigate risk and end the use of alternative clothing.

113. On 9 November, Mr Dawes-Clarke barricaded his cell and tied a ligature around his neck. He was moved to the IPD into a constant supervision cell (with a standard cell door rather than a barred gate) and placed in alternative clothing with observation levels raised to a minimum of two per hour. The cell had no furniture, and his bedding was removed (although he still had a bed, mattress and pillow), meaning that Mr Dawes-Clarke was now held in special accommodation. Mr Dawes-Clarke had used torn strips from his mattress cover to make a ligature on 25 October, and staff had raised concerns about the risks of these covers. When Mr Dawes-Clarke was placed in alternative clothing and special accommodation, the removal of his mattress/pillow covers, which he had demonstrated could be torn, was not considered.

114. Mr Dawes-Clarke remained in alternative clothing for over 24 hours, without any bedding or furniture, until he died. There was no evidence that this was reviewed or

authorised by an operational manager, and he was not observed five times per hour.

115. Special accommodation should be used to manage violent prisoners, to mitigate the impact of that risk. Instead, Mr Dawes-Clarke was placed in this accommodation seemingly to manage his risk of suicide and self-harm. Elmley did not follow national guidance, did not monitor him in line with this guidance, and did not review the arrangements or plan how to keep them in place for the shortest possible time.

116. In summary, Mr Dawes-Clarke's ACCT management was very confused. On one hand, staff instigated processes that are usually reserved for those prisoners who are judged to be at the highest risk of suicide and self-harm. At the same time, the frequency of ACCT observations was that usually seen for someone whose risk is moderate but not considered to be immediate, and there was no support plan to mitigate these risks. Senior management oversight that should have happened did not, which might have allowed for a clearer view of the level of risk Mr Dawes-Clarke presented.

117. Since Mr Dawes-Clarke died, Elmley has introduced an action plan to improve the quality of ACCT case management. They have also reviewed their procedures on the use of alternative clothing and special accommodation. This established that use of these facilities should be authorised by the duty operational manager, who should then chair an ACCT case review to identify how to reduce risk and end their use as soon as possible.

118. HMIP, in their inspection of March 2022, identified that the safer custody team was well resourced and had recently introduced some good initiatives and safeguards to identify and support prisoners at risk. Those subject to ACCT measures were generally positive about the care they received, although there were some weaknesses in the process itself. There was an action plan to improve the quality of case management.

119. While we appreciate that Elmley has recognised deficiencies in the management of ACCT procedures and taken steps to improve practice since Mr Dawes-Clarke's death, we are concerned that his ACCT was poorly managed, fell far short of expected standards, and did little to support him. We make the following recommendation to ensure similar failings are not repeated:

The Governor should investigate the quality of and compliance with policy of ACCT management, including the use of alternative clothing and special accommodation, in the previous 12 months, identify any improvements required, and devise a robust plan to deliver those improvements.

Use of Force

120. Prison staff applied force to Mr Dawes-Clarke twice in the time before he died: on 25 October 2021, and again immediately before he died. The Prison Service Use of Force Policy Framework states that force should only be used:

- If it is reasonable in the circumstances;
- If it is necessary;
- If no more force than is necessary is used; and

- If it is proportionate to the seriousness of the circumstances.

121. The Use of Force Training Manual, Section 11 (Medical) states:

> 'Under no circumstances should staff put any body weight on the neck, chest abdomen or back of the person being restrained. Neither should there be any hold around the neck as otherwise blockage of the airway can occur, leading to unconsciousness and death'.

122. The advice then states;

> 'Restraint Asphyxia can result from any restraint position where there is obstruction of the airway or where movement of the rib cage or abdomen is limited. Examples include: In the prone position – the person's body weight, as well as the additional weight of restraining staff, can make movement of rib cage less effective so only small volumes of air can go in and out of the lungs. Seated restraints – stomach and other contents of the abdomen are squashed and may be pushed upward limiting the movement of the diaphragm and making it difficult to take deep breaths'.

123. During use of force training staff are told that following exertion or when someone is upset or anxious, the demands of the body greatly increase. If the body cannot deal with the additional demand for breathing (particularly during or following the stress of a physical struggle), this is dangerous and may lead to death within a few minutes. Therefore, the duration of restraint must be kept to a minimum. Throughout this period, staff must continuously attempt to de-escalate the situation.

124. All staff should be aware that they have a duty of care towards prisoners and should monitor their welfare throughout the course of any incident. The Use of Force Policy states that a healthcare professional (when there is one on site) must attend a use of force incident as a priority, to take an active role in ensuring the medical wellbeing and safety of a prisoner under restraint, including by providing clinical advice to the incident supervisor in the event of a medical emergency.

125. The Use of Force Policy Framework also states that BWVC must be used to record events that could potentially lead to using force, and to record force being used.

126. All the prison officers involved in restraining Mr Dawes-Clarke had Prison Service training in control and restraint (C&R) techniques and all had completed refresher training within the previous 12 months. (The investigator was provided with evidence this training had been completed.) The accounts of the restraints from the officers involved in both incidents are broadly consistent.

25 October 2021

127. During a review of CCTV footage, the investigator identified that staff had used force when Mr Dawes-Clarke initially refused to return to, and then slowly walked towards, his cell on the morning of 25 October. Footage shows that Officer A jumped on Mr Dawes-Clarke's back, with her arms around his neck. This is not an approved C&R technique and could potentially be very dangerous. She recorded that she initiated force primarily to prevent harm, assault or harm to others. However, the footage that we viewed does not reflect this and instead shows Mr

Dawes-Clarke walking passively towards his cell. He does not appear to be speaking to anyone and is not displaying behaviour that we believe could be interpreted as threatening or aggressive. No one recorded the events on BWVC.

128. The investigator contacted the then Governor to ask that the use of force for this day was reviewed. He tasked the Head of Residence, Services and Use of Force, to review the use of force and provide the investigator with a report of his findings.

129. The Head completed a quality assurance review report. He concluded that the use of force was reasonable, given the potential disruption to the regime, and noted that at the time of this incident BWVC's were rarely used to proactively record incidents of this nature. He found that Officer A's actions were not an approved C&R technique and that her use of the head control was a poor decision. He did not deem this incident serious enough for escalation to the Deputy Governor for consideration for a code of conduct investigation. (Officer A has since been promoted and is now a C&R instructor.)

130. The footage that we have seen is concerning. Mr Dawes-Clarke was returning to his cell, albeit slowly. We have not seen any evidence that leads us to agree that this use of force was reasonable, necessary or proportionate to the circumstances.

10 November 2021

131. On 10 November, prison staff and paramedics made the decision that Mr Dawes-Clarke should be clothed before he was transported to hospital, because he was naked from the waist down. When two officers attempted to put boxer shorts on him, Mr Dawes-Clarke lashed out and kicked one officer in the leg. He also waved his arms scratching the other officer, and a paramedic left the cell as they feared for their safety. Both officers then attempted to gain control of Mr Dawes-Clarke. We note that after Mr Dawes-Clarke had ligatured, he never spoke or made any intelligible sound. Mr Dawes-Clarke was described by healthcare and prison staff as moving on the floor in an uncoordinated and apparently involuntary manner. After a seizure (post ictal phase) it is common for individuals to be confused and agitated and they may have a reduced level of consciousness.

132. The events that led to the restraint being initiated were not captured on BWVC. The restraint started at around 6.00pm, but only the last three minutes, from 6.07pm, were captured. Without any evidence from BWVC footage, we are not able to say whether the restraint was necessary or whether approved C&R techniques were used at the start of the restraint. The footage we have seen shows the following:

- Mr Dawes-Clarke can be heard making growling/moaning noises; he did not speak, made no threats, and appeared to be passive throughout.

- The assistant duty manager asked paramedics if it was okay to for Mr Dawes-Clarke to be cuffed, in the absence of healthcare staff, and one paramedic responded that he could be. Paramedics are not trained to give such advice in a prison situation, neither is it clear that they had full details of Mr Dawes-Clarke's medical history. Prison healthcare staff were not present for most of the events with the two prison GPs having left the prison entirely and nurses having left the scene some time earlier.

- With his hands cuffed behind his back, officers attempted to sit Mr Dawes-Clarke up. From what we have been able to establish, he had been lying down since the ligature was removed at 4.43pm. No advice or clinical observation appears to have been sought before the decision was made to sit him up.

- Mr Dawes-Clarke was sat up, leaning forward. He remained silent. Mr Dawes-Clarke quickly became unresponsive when he was lifted from the floor to sit him on his bed and was laid back down on the floor. Handcuffs were removed, and he was placed in a rudimentary recovery position.

133. Prison staff told us during interviews that they were aware that Mr Dawes-Clarke had an extensive history of staff assaults, that they believed that he was being non-compliant with their instructions and had consciously lashed out. They did not consider that these movements were involuntary, despite Mr Dawes-Clarke having been treated with diazepam for a suspected seizure. They were not provided with any reliable and up to date clinical information about Mr Dawes-Clarke's level of consciousness and believed the correct decision was to restrain him.

134. A member of the National Incident Management Unit of HMPPS produced a report for Kent Police dated April 2023, which reviewed Mr Dawes-Clarke's restraint. He noted the small space within the cell and that from BWVC footage, an officer had one knee resting on Mr Dawes-Clarke's torso; he was not able to form an opinion on the degree of pressure being applied through the officer's knee. The officer said that he had no recollection of placing his knee on Mr Dawes-Clarke, nobody had told him to remove his knee during the restraint and he was unaware that this had been identified until asked during his interview with the PPO investigator.

135. The member concluded there was a possibility that Mr Dawes-Clarke's actions [lashing out] could have been associated with him trying to breathe.

136. The Use of Force Training Manual 2015 V2.1 includes the provision for handcuffing in the seated position. However, all instructors have since been advised to remove this from training due to the potential risks associated with the seated position, and notably after a physical restraint when the prisoner is leant forward for handcuffs to be applied. This advice pre-dated Mr Dawes-Clarke's death, but the member was unable to find any documented evidence for when it was formally activated.

137. The member concluded that the use of force techniques used by officers were proportionate to the risk and followed where possible the training provided to staff, except for pressure being placed on the torso of Mr Dawes-Clarke and handcuffing in the seated position.

138. Elmley had not completed their own review of the circumstances leading up to Mr Dawes-Clarke's death and none of the officers involved in the restraint had been offered the opportunity to review events. The response nurse said during interview that he had not been told that Mr Dawes-Clarke had been restrained until a few days after his death and was not provided with any details during the resuscitation.

139. The investigator asked the then Governor if a review of the use of force could be done retrospectively, following Elmley's current policy of quality assurance reviews. He instructed the member to complete this review. The member found that, having read all available statements and reviewed all available BWVC footage, staff

conduct was good, the speed of response was good, and staff were acting in the best interests of their and Mr Dawes-Clarke's safety at the time the restraint was initiated. The member found no evidence to substantiate any staff misconduct, and no techniques used which caused deliberate harm to Mr Dawes-Clarke.

140. Nevertheless, the events around Mr Dawes-Clarke's death are concerning. Healthcare staff were not involved as they should have been. Mr Dawes-Clarke had self-strangulated and was unresponsive since. The clinical reviewer concluded that it was probable that the arm and leg movements he made when officers attempted to put underwear on him were involuntary, but this does not appear to have been considered or recognised by staff and they received no assistance from healthcare staff or the attending paramedics in this regard. Some of the techniques used by staff were not approved and were particularly dangerous given Mr Dawes-Clarke was not coherent or fully responsive.

141. The decision to use force should have been subject to a healthcare assessment of Mr Dawes-Clarke's clinical state. While it cannot be established definitively whether, or to what extent, the restraint played a part in Mr Dawes-Clarke's death, had paramedics or healthcare staff intervened and reassessed his level of consciousness, due to the seizures and the medication delivered, it is possible there would have been a different outcome.

Conclusion

142. Force was used twice on Mr Dawes-Clarke in the time leading up to his death. Both had significant consequences. The first incident seemingly triggered Mr Dawes-Clarke to attempt to take his life. The second incident immediately preceded his death.

143. We do not consider that force was reasonable or necessary in the first incident. Although staff told us that Mr Dawes-Clarke had a history of violence and assaulting staff, there had been no such incidents since he returned to prison around seven months before he died (although we appreciate that he had recently threatened to punch a hospital doctor). While he had initially refused an order, at the time of the first use of force Mr Dawes-Clarke was complying with staff instructions to return to his cell.

144. Mr Dawes-Clarke was a stockily built black man and we note that HMIP's thematic review, *The experiences of adult black male prisoners and black prison staff,* published in December 2022, showed that statistically black prisoners accounted for disproportionately more use of force incidents. Figures from Elmley show that, in 2022 (the year for which we were provided data), black prisoners were over-represented in the use of force. The IMB also noted that black prisoners were over-represented in some of the more negative aspects of prison life at Elmley, including segregation and adjudications. In 2021-22, Elmley upheld nearly a third of discrimination complaints made by prisoners (although these numbers have since reduced).

145. While we cannot say for certain that Mr Dawes-Clarke's race was a contributing factor in the decision to restrain him on 25 October, we cannot discount this. We make the following recommendations:

The Governor and Head of Healthcare should ensure that there is clear guidance and training for all staff on the safe use of force, in particular on all risk factors in relation to positional asphyxia, that they understand the circumstances in which force is reasonable and justified, and that they are empowered to intervene when they feel the need to do so.

The Governor and Head of Healthcare should ensure that clinical staff are consulted whenever possible before a use of force and attend any unplanned use of force as soon as possible, especially where a prisoner has already experienced a medical emergency.

The Governor should commission the National Incident Management Unit to review the use of force on 25 October 2021, and implement any recommendations they make.

Body worn video cameras

146. None of the officers present during the initiation of force, in either of these incidents, used a body worn video camera (BWVC). PSI 04/2017, Body Worn Video Cameras, states it is mandatory for staff to use BWVCs at any reportable incident (as outlined in PSI 11/2012, Management and Security of the Incident Reporting System) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

147. PSI 04/2017 also states that BWVC must be used 'when a user has or may be required to exercise force against a person or persons', and 'when a user believes an interaction presents or is likely to present a risk to the safety of the user, other members of staff or other persons present'. The BWVC Policy Framework states that, 'Staff should recognise when a situation is beginning to escalate and must consider starting to record as early as possible, which may act as a de-escalation tactic'.

148. We note that HMIP found in February 2023 that there had been significant improvements made in the use of BWVCs and review of use of force incidents, so we do not make a separate recommendation.

Clinical Care

149. The clinical reviewers identified that Mr Dawes-Clarke's long-term physical healthcare was difficult to manage. They found that while some aspects of his care were equivalent to that he could expect to receive in the community, others were not. We do not repeat these recommendations, but the Head of Healthcare should ensure that they are addressed.

Mental health

150. Mr Dawes-Clarke had diagnoses of personality disorder and ADHD but did not always engage with his identified treatment programmes.

151. After Mr Dawes-Clarke was restrained on 25 October, he became more paranoid – about the threat of violence from other prisoners and for the safety of his family. He began to tie ligatures after a period of stability. The mental health team reviewed him, and both a mental health nurse and the psychiatrist noted the difference in his

presentation. Both describe changes in his presentation which they considered related to possible emerging mental illness, rather than behavioural issues, which necessitated further observation and review.

152. On 10 November, the psychiatrist prescribed an anti-psychotic medication for Mr Dawes-Clarke. This was to try to reduce his agitation and observe the response to the medication closely and would have helped to inform an emerging diagnosis. Mr Dawes-Clarke never received this medication as the first dose was due on the evening that he died.

153. The clinical reviewer concluded that the mental health care Mr Dawes-Clarke received was equivalent to that which he could have expected to receive in the community. He was seen quickly by the mental health team when his mental health appeared to decline and had a consultant psychiatrist review. The clinical reviewers found this was in line with his needs and was a prompt response. While no diagnosis was immediately apparent, appropriate support was put in place and medication offered.

Emergency response

Requesting an ambulance

154. When Elmley's control room contacted the Ambulance Service, they used the term 'code blue' which the 999 operator did not recognise, and the control room staff were unable to provide any details about Mr Dawes-Clarke's medical situation.

155. The calls between the control room and ambulance service must have been mutually frustrating. It has been acknowledged by HMPPS nationally that policy and practice with regard to calling ambulances is not optimal. We are aware of ongoing work, commissioned by the Director General of HMPPS and in collaboration with health partners, to address the issue of control room staff immediately calling an ambulance (following a code blue) and being unable to answer basic questions about the prisoner's medical condition. We therefore make no recommendation.

Administering diazepam

156. Shortly after the ligature was cut from Mr Dawes-Clarke, he began to experience what the two GPs present concluded was a generalised seizure. As the seizure continued and did not ease, they concluded that they needed to treat him with a standard approach for 'status epilepticus' (a convulsive seizure that continues for more than five minutes, or convulsive seizures that occur one after the other with no recovery between), which is by the use of rectal diazepam. They administered two doses of 10mg. The specific timings of the doses were not recorded, and we cannot therefore be certain of the gap between the doses. When Mr Dawes-Clarke's seizure continued, they gave a third (7.5mg) dose of diazepam as an injection into his muscle.

157. NICE guidance (NG217 – Epilepsies in children, young people and adults) does not include advice on the intramuscular delivery of diazepam in these circumstances. The GPs said that they thought that gaining seizure control was vital and this was the only other method available to them, as intravenous use was not possible because it requires full resuscitation facilities, and the paramedics had not yet

arrived. The total dose of diazepam delivered was 27.5mg. The British National Formulary notes that the dose range is up to 40mg. Mr Dawes-Clarke was an adult weighing 113kg and therefore the dose administered was within the acceptable range.

158. The overall clinical rationale for the treatment was that the longer a generalised seizure continues the greater the risk of brain damage. The GPs were aware that the location of the prison meant that ambulances often take a longer time to reach them than is ideal. The clinical reviewers found that it was beyond the scope of their review and expertise to consider if the administration of diazepam was the ideal treatment in these circumstances and has invited His Majesty's Coroner to seek further expert advice.

Emergency care following a seizure

159. There were no detailed timings in the medical record of the initial response to the emergency or the management of the seizure. The entries in Mr Dawes-Clarke's medical record by a nurse and both GPs lack detail both of what they saw and what they did, when compared to what they noted in their statements and to what they were able to recall at interview. One of the GPs handed over in person to the paramedics when they arrived at the prison, the other wrote up the record which was later given to the paramedics. Both GPs then left the prison as it was the end of their working day (we consider the absence of any prison healthcare staff at the scene in more detail below).

160. After the GPs left, the paramedics became concerned about the dose of diazepam administered. The paramedics said that they thought Mr Dawes-Clarke may have been given an overdose of diazepam (the maximum dose a paramedic can administer is 20mg). Mr Dawes-Clarke's pulse was elevated, but his respiratory rate, oxygen saturation in air and blood pressure were all normal. Paramedics assessed Mr Dawes-Clarke's level of consciousness as GCS14, indicating an almost normal level of consciousness, which would have included obeying commands and being orientated. Although he was assessed as fully conscious, and no further concerns had been identified about his airway, paramedics tried to support his airway by inserting a tube, first into his mouth and when he did not tolerate this, up his nose. Both attempts failed. The clinical reviewers noted that it is unclear if simple, less intrusive methods such as head tilt and jaw thrust had been tried, if there was a concern about Mr Dawes-Clarke's airway.

161. When paramedics carried out further checks, Mr Dawes-Clarke was uncooperative, and this was interpreted as conscious behaviour. The clinical reviewers reflected that it was unclear how the ongoing effects of seizures were considered by the paramedics or whether they considered that he was post ictal. The clinical reviewers stated that it was also difficult to reconcile the certainty of the paramedics that Mr Dawes-Clarke was fully conscious of his actions, when they believed that he had been given an overdose of diazepam.

162. The clinical reviewers found there was considerable difference between the assessment by the paramedics that Mr Dawes-Clarke was fully conscious and knowingly resisting staff, to a man who needed airway support in the form of a tube being inserted into his throat or nose. Use of oral or nasal airways is very uncommon in fully conscious patients because an oral airway is likely to induce

gagging and cannot be tolerated. Nasal airways may be better tolerated. The clinical reviewers reflected that paramedics were very focused on their view of the dosage of diazepam that had been administered, with little evidence they considered, to the same level, the overall condition of Mr Dawes-Clarke who was post ictal and very likely to be agitated and confused.

163. Two nurses had been redirected back to the routine duties of the prison by the then Head of Healthcare. The Head had also left the prison as she was aware that the paramedics were in attendance. This meant that there was no one immediately available for officers to ask for advice, other than the paramedics. We note that the prison healthcare team was experiencing staffing issues at this time. However, the absence of a registered member of prison healthcare staff, or the GPs, during a medical emergency was not acceptable and, we consider, had serious consequences for Mr Dawes-Clarke when officers restrained him in the absence of any ongoing advice about his medical condition from clinicians. We make the following recommendations:

The Head of Healthcare should ensure that there is always a registered nurse or a GP present during a medical emergency. Guidance on the role of GPs and senior managers during an emergency should be developed, detailing guidance on leadership, handover and what staff must do before they return to their usual duties or leave the prison.

The Head of Healthcare should ensure that all healthcare staff understand their role in an emergency response, including recognising and managing seizures or loss of consciousness in line with current clinical guidelines, and recording actions taken. A local protocol, in line with NICE Guidance should be developed and training provided to ensure staff at all levels understand what is required.

Resuscitation

164. Mr Dawes-Clarke stopped breathing and his heart stopped while he was under restraint. There was no immediate clinical assessment of his condition when he went limp at 6.10pm. Officers were unsure if Mr Dawes-Clarke was conscious or not. There was no prison healthcare member of staff present and although paramedics were stood immediately outside the cell they were not asked to intervene, but also did not appear to volunteer to assist Mr Dawes-Clarke.

165. No active resuscitation began until the response nurse initiated this at 6.13pm. He said in interview that he did not understand why everyone was standing back and recalled saying something like ‘this is your fucking domain…this is your job’ to the paramedics.

166. The nurse and the officers undertook chest compressions, while paramedics left the prison to collect equipment from the ambulance. All three of the paramedics left the prison at least once to collect equipment from their vehicle. The paramedics did not appear to take charge of the resuscitation attempt until around 6.23pm, when they administered adrenalin.

167. While this must have been an unusual case for the ambulance service, we have been unable to identify if SECAmb undertook any internal investigation with the

paramedics. Consideration should be given as to the best approach to take in such cases, so that immediate memory is captured, and any immediate risks can be mitigated.

168. The actions of paramedics from SECAmb are outside the remit of the PPO investigation. We cannot say what they thought their role was in advising on restraint as they did. The clinical reviewer has reflected that the attempts to insert an airway in a conscious man who was not exhibiting breathing problems were difficult to understand clinically, and paramedics were possibly over focused on their (incorrect) view that the maximum dose of diazepam had been exceeded.

169. After Mr Dawes-Clarke's death, the then Deputy Governor of Elmley submitted a complaint about the actions of paramedics. The complaint detailed that: prison staff were concerned about paramedics' behaviour towards Mr Dawes-Clarke, in that he was sworn at while a blood pressure cuff was being applied; that paramedics remained outside the cell when Mr Dawes-Clarke deteriorated, and they should have recognised signs the situation was a medical emergency; and that some of their equipment was missing. In response to this complaint, a SECAmb Operations Manager concluded in a reported dated 19 December 2021, that the complaint was partially upheld as the correct equipment was missing from the defibrillator (but this was not the fault of the paramedic crew) but there was no other learning.

170. The clinical reviewers concluded that the overall approach to managing the resuscitation cannot be seen as acceptable. We make the following recommendation:

NHS England and SECAmb should conduct an investigation into the circumstances surrounding Mr Dawes-Clarke's resuscitation, including the actions of paramedics in attendance.

Support for staff

171. Healthcare staff told us that they were not invited to a debrief following Mr Dawes-Clarke's death. Several healthcare staff and some prison staff told us that they did not feel properly supported afterwards.

172. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

173. Although Postvention procedures were not routinely adopted at the time Mr Dawes-Clarke died, the principles of supporting staff were the same. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff involved in a death in custody, and those that are identified as significant to the deceased, should be offered support in line with Postvention procedures.

174. This investigation report sets out a great deal of learning for both prison and healthcare staff, who told us that they had not had the opportunity to reflect and discuss events in a guided and supportive manner. The Governor and Head of Healthcare will want to think broadly about how to ensure the many staff involved have an opportunity to reflect on the findings of this report.

Governor to Note

First aid training

175. The investigation highlighted that not all custodial managers or supervising officers are first-aid trained or have been trained to use a defibrillator. (The duty manager and Officer B said that they had completed first aid training but could not recall the last time they did, so their training was lapsed. The assistant duty officer and another officer, who is based in the IPD, had not completed first aid training.) While nursing staff at Elmley are at the prison 24/7, training staff in basic life saving techniques, especially those whose role is to respond to and manage incidents, could be crucial.

Family liaison

176. Mr Dawes-Clarke's family were upset that they were given inaccurate information by the prison FLO. In two subsequent deaths at Elmley, issues around FLO contact have been identified. The Governor must ensure family liaison officers provide the bereaved family with accurate information, in line with national policy.

Head of Healthcare to Note

177. The healthcare provider at the time, IC24, undertook only a very brief investigation before the police involvement led to a suspension of a more detailed review. While a police investigation must take precedence, it should also have been possible to gather statements of fact, dated and signed from all the healthcare staff who were involved in the events surrounding Mr Dawes-Clarke's death to establish a clear timeline and to identify any immediate issues.

Inquest

178. The inquest into Mr Dawes-Clarke's death concluded in July 2025. The jury returned a narrative verdict - from hearing all the evidence presented to us, we conclude that Mr Dawes-Clarke died from a combination of factors beginning with the compression of neck via self-inflicted ligaturing. This was followed by a disproportionate use of force by prison officers during control and restraint which led to Mr Dawes-Clarke going limp. After restraint, there was insufficient action taken by prison staff and paramedics upon realising Mr Dawes-Clarke's cardiac and respiratory arrest. From the body-worn footage, it is evident that prison staff neglected to consider Mr Dawes-Clarke's head positioning and breathing throughout the restraint. The poor practice of applying handcuffs while Mr Dawes-Clarke was in a kneeling position more than minimally increased the risk of positional asphyxia.

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