Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Higginson, a prisoner at HMP Rye Hill, on 2 September 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

3. In March 2020, Mr Donald Higginson was sentenced to 15 years imprisonment for sexual offences. He died of a combination of respiratory failure (lack of oxygen and excess of carbon dioxide) and hyponatraemia (lack of sodium in the bloodstream). This was caused by paraneoplastic pseudo-obstruction (a digestive disorder) and syndrome of inappropriate antidiuretic hormone (a syndrome which causes the body to retain too much water) which, in turn, were caused by lung cancer. He was 71 years old when he died on 2 September 2024 in hospital. We offer our condolences to Mr Higginson's family and friends.

4. The Ombudsman's office wrote to Mr Higginson's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Higginson's clinical care at HMP Rye Hill.

6. The clinical reviewer concluded that the clinical care Mr Higginson received at Rye Hill was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations not related to Mr Higginson's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Higginson's care. We did not find any non-clinical issues of concern. We make no recommendations.

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

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

Inquest

The inquest hearing was held on 7 July 2025. The Coroner concluded that Mr Higginson died of natural causes.

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