Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Dawson, a prisoner at HMP Lindholme, on 14 February 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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. On 23 March 2023, Mr Michael Dawson was sentenced to five years imprisonment for arson.

4. Mr Dawson died of an epileptic seizure on 14 February 2024 at HMP Lindholme. He was 39 years old. We offer our condolences to Mr Dawson's family and friends.

5. The Ombudsman's office contacted Mr Dawson's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Dawson's family asked about the healthcare Mr Dawson received in prison and whether he took his medication. The family's questions have been addressed in the clinical review.

6. NHS England commissioned a clinical reviewer to review Mr Dawson's clinical care at the prison. She concluded that the clinical care Mr Dawson received at Lindholme was not of the required standard and therefore not equivalent to what he could have expected to receive in the community, because healthcare staff failed to put a care plan in place to manage Mr Dawson's epilepsy.

7. We make the following recommendations:

   The Head of Healthcare should ensure that when patients refuse to attend outside hospital against medical advice that a two-stage mental capacity assessment is undertaken to ensure the patient fully understands their decision making and this is documented into the SystmOne medical records for the wider multi-disciplinary team.

   The Head of Healthcare should ensure that all staff are trained and competent in NEWS2 assessment, scoring, and calculation. This will ensure that patients who are deteriorating, or at risk of deteriorating will have a timely initial assessment by a competent clinical decision maker.

   The Head of Healthcare should ensure that all patients with long-term conditions including epilepsy have an individualised management plan that includes the out of hours provision.

   The Head of Healthcare should ensure that when there is an increase in seizures in individuals with a diagnosis of epilepsy that a seizure chart is used to ensure that patients are monitored to see if there is a pattern to the seizures and further escalation of treatment can be planned.

8. The PPO investigator investigated the non-clinical issues relating to Mr Dawson's care. While healthcare staff suggested that Mr Dawson be placed in a shared cell as he had epilepsy, we found that Mr Dawson refused to move. We did not find any non-clinical issues of concern.

9. The initial report was shared with HM Prison and Probation Service (HMPPS) and the healthcare provider, Practice Plus Group. No factual inaccuracies were identified.

10. At the inquest held on 20 January 2026, the coroner concluded that Mr Michael Dawson died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **December 2024**

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