Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Dawes, a prisoner at HMP Nottingham, on 5 July 2025

A report by the Prisons and Probation Ombudsman

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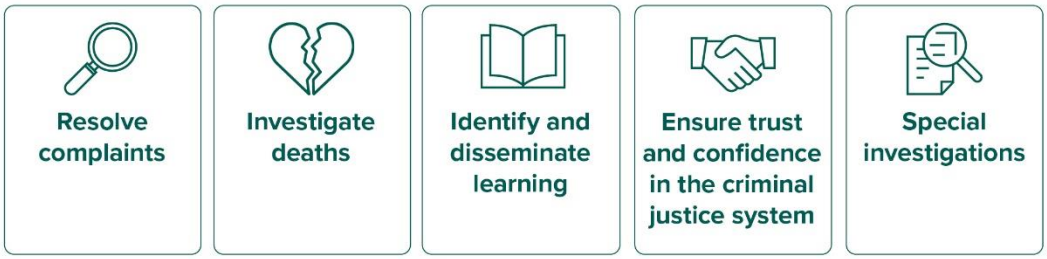
OUR VISION

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 May 2005, Mr John Dawes was sentenced to 24 years in prison for drug related offences. He was released from prison in January 2017 but was recalled in January 2025 due to breaching his licence conditions. He died in hospital of lymphoma (cancer of the lymphatic system) on 5 July, while a prisoner at HMP Nottingham. He was 56 years old. We offer our condolences to Mr Dawes' family and friends.

4. The Ombudsman's office wrote to Mr Dawes' 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 Dawes' clinical care at HMP Nottingham.

6. The clinical reviewer concluded that the clinical care Mr Dawes received at Nottingham was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Dawes' medical records contained evidence of kind, respectful and compassionate interactions between healthcare, custodial teams and Mr Dawes. The clinical reviewer made one recommendation not related to Mr Dawes' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Dawes' care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Nottingham Healthcare NHS Foundation Trust. They found no factual inaccuracies.

10. At the inquest, held on 28 August 2025, the Coroner concluded that Mr Dawes died from natural causes.

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

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