

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Lawton, a prisoner at HMP Doncaster, on 19 December 2025

A report by the Prisons and Probation Ombudsman

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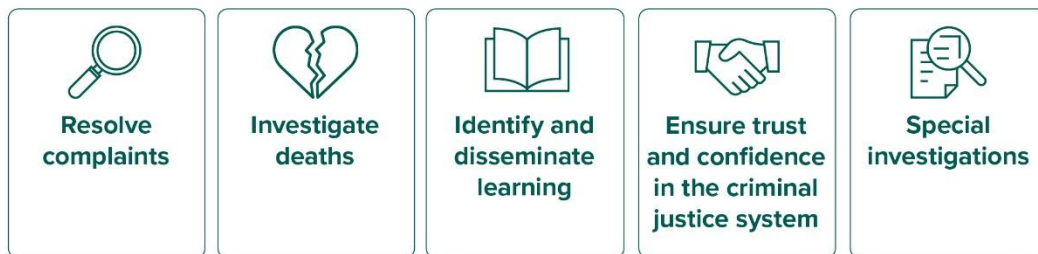
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OUR VISION

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



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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 14 June 2018, Mr Mark Lawton was sentenced to nine years in prison for robbery. He died of acute myocardial ischaemia (when the heart muscle is starved of blood) on 19 December 2025, at HMP Doncaster. He was 52 years old. We offer our condolences to Mr Lawton's family and friends.
4. The Ombudsman's office wrote to Mr Lawton's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
5. NHS England commissioned an independent clinical reviewer, to review Mr Lawton's clinical care at Doncaster.
6. The clinical reviewer concluded that the clinical care Mr Lawton received at Doncaster was of a reasonable standard and was equivalent to that which he could have expected to receive in the wider community. He found that when Mr Lawton's condition worsened, his deterioration was promptly assessed and the clinical team responded appropriately.
7. The clinical reviewer made no recommendations.
8. The PPO investigator investigated the non-clinical issues relating to Mr Lawton's care. We did not find any non-clinical issues that warranted a recommendation but bring the Director's attention to the below.
9. We shared the initial report with HM Prison and Probation Service (HMPPS) and Healthcare (Practice Plus Group). They did not find any factual inaccuracies.

Director to note

Use of restraints

10. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
11. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as

circumstances change. The Prevention of Escape: External Escorts Policy Framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and ill health.

12. On 25 September 2025, Mr Lawton was escorted to hospital. The escort risk assessment, completed before Mr Lawton was escorted, said that both his risk to the public and his risk of escape was low. The medical section of the form recorded no medical objection to the use of restraints and said that no medical conditions needed to be considered. The risk assessment section of the form recorded that Mr Lawton should be restrained with a single cuff (where the prisoner wears one cuff and the other is attached to the wrist of an officer). Staff later recorded that Mr Lawton was not restrained when he attended hospital due to his mobility and illness. Doncaster told us that the decision not to handcuff Mr Lawton prior to escort was made by the discharging manager in reception and that any decision to amend the use of restraints arrangements should be discussed and signed off by the duty director.
13. On 30 September 2025, Mr Lawton was again escorted to hospital. The risk assessment completed before Mr Lawton was escorted said that both his risk to the public and his risk of escape was low. The medical section of the form recorded no medical objection to the use of restraints and said that no medical conditions needed to be considered. Under a separate 'medical and social care' section, staff recorded that Mr Lawton required support with personal care and/or mobility, although no further information was provided. Under the heading of 'general risk assessment', staff recorded that there was no previous escorting information and no previous cuffing arrangements. The risk assessment section of the form recorded that Mr Lawton should be restrained with a single cuff. On this occasion, no one authorised removal of handcuffs before Mr Lawton went to hospital, although an escort chain was authorised instead of a single cuff due to Mr Lawton's frailty. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist.)
14. We asked Doncaster why they assessed that restraints needed to be used on Mr Lawton when he was escorted to hospital on 30 September, when he had been escorted five days earlier without the use of restraints. They told us that the information that Mr Lawton's cuffing risk assessment had been amended on 25 September had not been fed back to the security team. The security team were therefore unaware of this decision when they completed their risk assessment on 30 September, and they continued to assess that a single cuff restraint was required.
15. When completing the escort risk assessment, staff should ensure that they review the risk assessments from recent escorts to update and inform their decision making, particularly for older prisoners or those with poor mobility. This information and subsequent decision making should be clearly recorded on the relevant forms.

Adrian Usher
Prisons and Probation Ombudsman

May 2026

Inquest

At an inquest held on 9 September 2026, the coroner concluded that Mr Lawton died from natural causes.



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