

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Sean Williams, while in the custody of Prisoner Escort and Custodial Services (PECS), on 27 March 2024**

**A report by the Prisons and Probation Ombudsman**

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

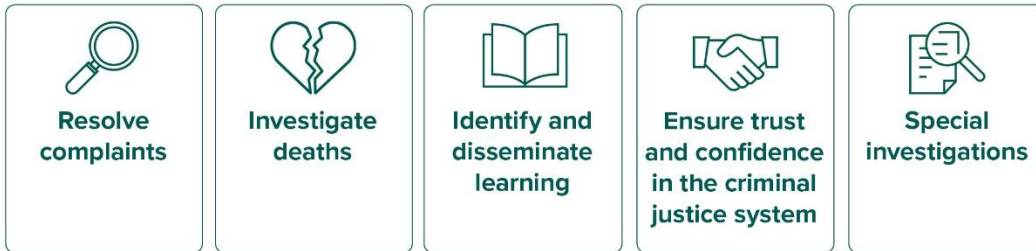
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 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



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## Summary

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. Mr Sean Williams died of heart issues on 27 March 2024, while in the custody of Serco, travelling from Thames Magistrates' Court to HMP Thameside. He was 47 years old. We offer our condolences to his family and friends.
4. We found that staff dealing with Mr Williams' medical emergency did not respond in a reasonable or justifiable manner. There was a significant delay between staff recognising that Mr Williams was having a serious medical emergency and opening his cell on the van to provide emergency medical care. Serco escort staff also failed to follow their local policy or to quickly pass on vital information to the 999 call handler, resulting in a significant delay to the paramedics' arrival. The standard operating procedures governing prisoner welfare and medical emergencies are unclear and should be revised and staff need further training.
5. Serco also do not have a standard operating procedure sufficiently identifying responsibilities if an individual dies in their custody. Senior Serco staff refused to have contact with Mr Williams' family.
6. Serco were unwilling to share relevant and pertinent information with the PPO during our investigation into Mr Williams' death. They also told us that the two members of staff present when Mr Williams died had not made any statements. This was not the case and the Coroner provided us with these statements 17 months after Mr Williams died.

## Recommendations

- The Serco Contract Director should ensure that there is a clear and detailed policy which outlines what staff should do in the event of a medical emergency during transportation. All staff should receive training to ensure they have understood their responsibilities during an emergency as outlined by this new policy.
- The Serco Contract Director should ensure there is a clear policy setting out the requirements for contact with next of kin following a death in PECS custody, including the appointment of trained PECS family liaison officers and that all relevant staff are aware of their responsibilities.
- The Serco Contract Director should ensure that the PPO has unfettered access to relevant information and receives this promptly when requested.

## The Investigation Process

7. HMPPS notified us of Mr Williams' death on 27 March 2024.
8. The PPO investigator interviewed six Serco staff. She was unable to interview PCO A and PCO B who were present when Mr Williams died. PCO A emigrated almost immediately after Mr Williams' death and could not be contacted. PCO B had a period of sick leave after Mr Williams died, and we were advised by occupational health staff (who advise on work-related health risks) that he could not discuss what had happened with us.
9. The investigator obtained copies of relevant extracts from Mr Williams' Serco escort record, and CCTV. She also obtained the investigation report prepared by Serco and commissioned by the MOJ (from the Coroner), the police custody detention log, and London Ambulance Service records.
10. The Ombudsman's office wrote to Mr William's father to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
11. Mr William's family received a copy of the draft report. They did not make any comments.
12. The initial report was shared with PECS and Serco. Serco pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

## Previous deaths in Prisoner Escort and Custody Service (PECS)

13. Mr Williams was the first prisoner to die in PECS custody since November 2023. There have been two further deaths in PECS custody since that of Mr Williams. These investigations are ongoing but our preliminary enquiries have revealed concerns over the emergency response following these deaths.

## Key Events

### Leyton Police Station

14. Police arrested Mr Williams on 25 March 2024 for alleged offences of assault and possession of a class A substance and took him to Leyton Police Station. His risk assessment identified him as having schizophrenia, for which he was not medicated, and noted that he had used heroin and crack cocaine that day. Police observed him every 30 minutes. They conducted a full search and recorded that they found a class A substance in his sock.
15. A healthcare practitioner medically assessed Mr Williams on 26 and 27 March. The practitioner identified that he was experiencing opiate withdrawal and administered supportive medications at 12.35am and 6.50am on 27 March. Mr Williams was not scheduled to receive any further medication until the evening of 27 March.
16. At 8.02am, police handed Mr Williams over to Prisoner Custody Officer (PCO) C, a Serco escort. PCO C could not recall transporting Mr Williams but stated that any issues would have been recorded on Part B of the Serco Escort Record system (SERs). No issues were recorded on the Part B.

### Thames' Magistrates Court

17. Mr Williams arrived at Thames Magistrates' Court at 9.12am and remained there until 4.59pm. Staff recorded only one search during this time, which took place after Mr Williams had a legal visit at 10.01am. Court Custody Manager (CCM) A told us that staff routinely conduct searches before and after any custody movement, including on arrival, before and after toilet use, legal visits, and appearances in the court dock.
18. At 11.37am, Mr Williams appeared in court, was remanded to custody and was waiting for transport to HMP Thameside. He used the toilet at 11.40am, 12.27pm, 12.28pm, 12.50pm, 2.23pm, and 4.03pm. Staff did not record any searches before or after these toilet visits or his court appearance. According to Serco policy, those in custody at Thames' Magistrates Court should be searched on exit from their cell, escorted to the toilet cubicle, searched on exit from the toilet cubicle and returned to their cell.
19. At 4.59pm, CCM A handed Mr Williams over to PCO A and PCO B.

### Transfer to HMP Thameside

20. The investigator reviewed CCTV footage (which has sound available) from the escort van, the Serco Escort Record from 27 March and the Serco internal investigation into events, which included statements from PCO A and PCO B. She also gathered information from the London Ambulance Service and the police. The following account draws on all these sources.
21. Mr Williams was on van that could hold six prisoners in separate cells. The driver sits in the front, separate to the back of the van. The second PCO sits in the back of

the van watching CCTV cameras, these show inside each of the cells on the van and have audio capabilities. The driver and second PCO can communicate via an intercom.

22. Mr Williams entered Cell 6 at 5.10pm and sat forward with his head down for most of the time. PCO B was driving the van and PCO A sat in the back. PCO A offered Mr Williams water but he initially declined. At 5.17pm, Mr Williams accepted water, and at 5.58pm asked for a tissue to blow his nose which PCO A provided. At 6.06pm, Mr Williams began banging his head in the cell, slumped forward, and then his body stiffened. He appeared to foam at the mouth. PCO A called to Mr Williams asking him if he was okay. At 6.07pm, Mr Williams slumped over in his seat, his breathing sounded abnormal, and he said, "please".
23. PCO A shouted to Mr Williams and told PCO B via the intercom what was happening. They discussed whether to call the Serco control office or an ambulance. At 6.08pm, PCO A dialled 999. At 6.11pm, PCO B parked the van at Thames Magistrates Court, having returned there, and entered the rear compartment.
24. The initial 999 call lasted 11 minutes and 14 seconds. The call cut out unexpectedly following this, and the call handler called back. The second call lasted seven minutes and 27 seconds. PCO A initially spoke to the call handler but struggled to provide accurate information including their location. PCO B took over the call five minutes into the call. Eight minutes and 57 seconds into the call, the call handler confirmed that he had the location of Thames' Magistrates Court but PCO B did not seem to be listening to the call handler and was making a call on another phone. The call handler repeatedly tried to confirm the location of the vehicle with PCO B until the line cut out. The call handler called back and repeatedly asked PCO B if Mr Williams was breathing and where he was. However, PCO B repeatedly failed to answer. Three minutes and 21 seconds into the second call, PCO B told the call handler that Mr Williams was not breathing. The call handler told PCO B that they must start CPR. However, PCO B said he was unable to as he could not open the cell door. In his statement, he wrote that Mr Williams' foot was preventing him open the door (although shortly after he was able to open the door with relative ease). Four minutes and 10 seconds into the second call, the call handler confirmed that the ambulance was on route.
25. Between 6.12pm and 6.22pm, both PCOs intermittently banged on Mr Williams' cell door and asked him whether he could hear them and whether he could get up. Mr Williams appeared to be slumped over in his seat during this period. He was making heavy breathing or gargling sounds.
26. After trying to open the door for less than a minute, at 6.22pm, PCO B managed to move Mr Williams' foot and opened his cell door. They moved Mr Williams out of the cell and began CPR at 6.25pm. Paramedics arrived at 6.26pm and immediately took over resuscitation efforts. They pronounced Mr Williams' life extinct at 7.46pm.

### **Contact with Mr Williams' family**

27. On 27 March at 9.30pm, Mr A, Serco Acting Assistant Director for the East region, informed Mr B, Assistant Director at HMP Thameside, of Mr Williams' death. Mr Williams had refused to give details of his next of kin when he was arrested. Mr A

tried to obtain contact details for his next of kin from the police station he had been held in. The police who responded to Mr Williams' death also told Mr A they would try and obtain his next of kin details.

28. Mr A told us that PECS have no trained family liaison officers. On 28 March at 12.20pm, Mr B appointed Custodial Manager (CM) A as the Family Liaison Officer. CM A liaised with Mr Williams' solicitor to try to identify his next of kin. On 2 April, CM A identified Mr Williams' father as his next of kin and obtained his telephone number but not his address. She left voicemails for him on 2, 3, and 5 April asking him to call her. At 2.50pm on 5 April, she spoke to him by telephone and broke the news that Mr Williams' had died, although he was already aware of his son's death. She decided to do this on the telephone rather than in person due to the amount of time that had already passed since Mr Williams had died. Mr Williams' father requested an in-person meeting on 8 April. CM A informed him that she was unavailable but assured him that someone else would attend. She emailed Mr A to advise him that a visit needed to take place in her absence as she was going on annual leave that day.
29. Mr A replied to CM A's email, stating that neither he nor Mr C, Serco Investigations and Security Manager, were available to conduct the visit, and he had not identified anyone else to attend. CM A did not receive this email as she had already left work. No one contacted Mr Williams' father to tell him that the visit would not take place on 8 April.
30. When CM A returned from annual leave on 12 April, she discovered that the visit had not occurred. She visited Mr Williams' father later that day.
31. During the visit, Mr Williams' father told CM A that he wanted to speak with a manager who had responsibility for Mr Williams' care. CM A informed Mr A and Mr C by email. Mr A replied, stating that no contact would occur with Mr Williams' family outside of her role. Mr A told us he believed Mr C would meet Mr Williams' father in person to return Mr Williams' property. Mr C told us he was never scheduled to do so.
32. No one had any further contact with Mr Williams' father after CM A had visited him on 12 April.

### **Post-mortem report**

33. The pathologist concluded that Mr Williams died of acute left ventricular failure (when the heart fails to pump blood effectively) and acute cardiac arrhythmia (a sudden problem with the heart's rate of rhythm). Low concentrations of morphine or heroin and cocaine were found in Mr Williams' system. The pathologist concluded that Mr Williams had not taken a large amount of heroin or cocaine shortly before his death. However, due to the amount of time between his arrest and his death, they noted it was possible that Mr Williams had taken heroin/morphine or cocaine after he was arrested.
34. The pathologist concluded that they could not be sure what had caused Mr Williams heart failure but that there were three potential possibilities:

- Sudden Adult Death Syndrome (SADS – unexpected, sudden death due to cardiac arrest);
  - Cardiac arrhythmia brought on by cocaine use; or
  - Sudden unexpected death in schizophrenia (the unexpected death of a person with schizophrenia when there is no other explanation for their death).
35. The pathologist noted that it might be worth further testing Mr Williams for synthetic cannabinoids or nitazenes. We do not know if any further tests were carried out.

## **Inquest**

36. The Coroner's inquest held in February 2026 determined the medical cause of death to be cardiac arrest caused by a combination of heart failure and pulmonary oedema.
37. The jury returned a narrative conclusion, stating that there were multiple failures which may have contributed to Mr Williams' death. There were failures in the adequacy of first aid training for Serco staff, failures to adequately assess the first aid knowledge and competence of Serco staff, a failure by Serco to provide clear guidance on emergency procedures, and there was an insufficient emphasis on urgency and the paramount importance of preserving life. They concluded that there may have been restriction to Mr Williams' breathing, brought about by the position in which he was left and the failure to put him in the recovery position, however the impact of this is unclear.

## Findings

### Emergency Response

38. Serco standard operating procedure (SOP), *Prisoner Welfare on Vehicles*, sets out that,  
  
"Where a prisoner is injured or taken ill on board a vehicle the Operational Control Centre [OCC] must be informed immediately. Where appropriate, First-Aid should be administered. Where required, the OCC will arrange for an ambulance to rendezvous with the vehicle or, alternatively, re-route the vehicle to the nearest hospital."
39. Serco SOP, *Duties of a Vehicle Escort Officer*, states that,  
  
"Officers are to be aware that opening a cell door on a vehicle represents a high escape risk only in exceptional circumstances may an escort officer unlock a vehicle cell door when the driver is not present. i.e., when a life-threatening incident is taking place and there is no other alternative."
40. We were unable to interview PCO A or PCO B. We have reviewed their Serco investigation statements and PCO B's police statement and the investigation report prepared by Serco at the request of the MOJ.
41. It took PCO A and PCO B almost two minutes after Mr Williams appeared to be having a medical emergency to agree to call an ambulance. There was a total time of over 15 minutes before the ambulance call handler was able to establish the location and severity of the emergency. It took 15 minutes for the PCOs to open Mr William's cell door after he began to appear to be having difficulties. It took a further 2 minutes and 28 seconds for PCO B to begin CPR.
42. PCO B said that he called the OCC after the paramedics had arrived.
43. The evidence the two PCOs provided to their employer in their statements does not present an accurate reflection of events. In addition, PCO A stated in his Serco interview that he did not open the cell door as he was satisfied he could hear Mr Williams' breathing and that an ambulance was on route. This was not the case, there was a period of almost nine minutes where the 999 call handler was unable to determine the location of the van and had not therefore dispatched an ambulance. According to the 999 call, PCO B said he could not open the cell door because it was blocked by Mr Williams' foot.
44. During interview as part of the Serco investigation, PCO A said that he was aware of the emergency procedures and had received the relevant training, but he was hesitant to open the cell door as he thought Mr Williams may have been faking illness. He stated that he was satisfied that he could hear him breathing and that an ambulance was on route.
45. It was clear that neither PCO A nor PCO B knew what information they needed to share with the ambulance call handler to ensure a priority response, and PCO B did not appear to be listening to the call handler when he was trying to determine the severity of the incident. The significant delay in opening Mr Williams' cell and

providing first aid was also unjustifiable. Overall, we find staff's handling of Mr Williams' medical emergency deeply concerning.

46. We interviewed PCO C, a Serco escort, who had been employed as a vehicle escort for approximately seven months. PCO C was unable to effectively describe what should occur if there was a medical emergency during a transfer. PCO C said that she would assess the situation and administer necessary first aid straightaway but we were not convinced that PCO C had a reasonable understanding of her responsibilities in a medical emergency.
47. Mr D, Deputy Head of PECS, told us that Serco are expected to follow HMPPS' policy and standards with regards to emergency responses. He said that while Serco own and implement their SOPs, PECS have a responsibility to review them. He said that after Mr Williams' death, one of the SOPs had been slightly amended to include that preservation of life was paramount. However, we have concluded that this is insufficient.
48. The current SOPs do not contain sufficient detail or clarity to empower staff to understand what their responsibilities are in a medical emergency. There have been two further deaths in Serco custody during transport in a van since that of Mr Williams. Our investigations into these deaths have been suspended due to ongoing police investigations. Following our preliminary investigations into these deaths, we are concerned that significant issues remain in Serco's response to emergencies when transferring prisoners. We therefore make the following recommendation:

**The Serco Contract Director should ensure that there is a clear and detailed policy which outlines what staff should do in the event of a medical emergency during transportation. All staff should receive training to ensure they have understood their responsibilities during an emergency as outlined by this new policy.**

## Family contact

49. Serco does not have a SOP covering family liaison following illness or death of someone in their custody. Mr D told us that Serco are required to comply with HMPPS policy.
50. Prison Service Instruction (PSI) 64/2011, *Safer Custody* (which was replaced by the Prison Safety Framework in January 2025), sets out the procedures that staff should follow when liaising with next of kin following a death in custody. It is best practice for the family liaison officer to notify the next of kin about a death face to face and as soon as possible to reduce the risk of family being informed via other sources. If notification in person is not possible, a visit must be arranged 'as soon as practicable' after the notification.
51. Having obtained Mr Williams' father's details on the 2 April, CM A tried to phone him several times over the next few days and was eventually successful in speaking to him on 5 April. She informed senior managers in Serco that he would like them to visit him three days later. No one from Serco visited him or informed him that they would not be meeting him. Mr Williams' father asked to speak to Serco managers when CM A visited him on 12 April. Again, they refused to have any direct contact

with him. Serco senior managers told us that they have no family liaison officers trained to operate within the PECS environment and rely on staff from prisons to fulfil this role. Mr D confirmed that this is not in keeping with their contractual obligations and he was also disappointed to hear that no Serco staff had been willing to meet with Mr Williams' father.

52. It is unacceptable that there is no sufficient Serco policy for liaison with families after an individual dies in their custody. It is shocking that, even when asked directly by Mr Williams' father, managers still refused any contact with him or afford him the courtesy to explain why. Family members of deceased individuals must be prioritised and treated with respect and humanity.

**The Serco Contract Director should ensure there is a clear policy setting out the requirements for contact with next of kin following a death in PECS custody, including the appointment of trained PECS family liaison officers and that all relevant staff are aware of their responsibilities.**

## PPO Liaison

53. We were repeatedly told by Serco that PCO B and PCO A did not make statements following Mr Williams' death. Following the pre-inquest review in September 2025, we learned that statements were made at the time of Mr Williams' death. The Coroner subsequently provided us with these.
54. We were also prevented from having access to the Serco internal investigation. We were initially told that we would need to receive approval from the PECS team, which we received. Following this approval, we were then continually informed that they were unable to share this report with us. Again, the Coroner provided us with this, 17 months after Mr Williams' death.
55. Subsequent PPO investigations have faced similar unacceptable disclosure issues. Under the PPO's terms of reference, we have unfettered access to material that is relevant to our investigations, and it is of great concern that obtaining such evidence from Serco is met with delay and obfuscation. We recommend:

**The Serco Contract Director ensures that the PPO has unfettered access to relevant information and receives this promptly when requested.**

## Serco Contract Director to Note

### Searching at court

56. There remains uncertainty about what caused Mr Williams' heart failure. The pathologist noted that toxicological analysis could not exclude any use of illicit drugs following arrest. Mr Williams had a history of drug use, he was arrested for drug related offences, and on being searched at the police station was found to have drugs concealed in his sock. Mr Williams was searched in police custody and again in Serco custody, and nothing further was found on his person. We are unable to state with certainty whether Mr Williams did, or did not, use any drugs between arrest and his death. The pathologist could not rule out that Mr Williams had taken cocaine or heroin/morphine at some point after he was arrested and noted that

cocaine was one of the possibilities that may have caused his heart failure. Toxicological analysis did not include psychoactive substances such as synthetic cannabinoids.

57. CCM A told us that searches take place after every movement in court custody, but these were not evidenced in Mr Williams' records. There was only a note of one search taking place. The Serco Contract Director will want to ensure that searches are properly undertaken in line with policy and evidenced in an individual's record.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**January 2026**

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100