

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Davison a prisoner at HMP Holme House on 7 May 2020

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Ian Davison, who was 42 years old, died of cancer on 7 May 2020, at HMP Holme House. We offer our condolences to Mr Davison's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Davison received was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation but as it was not directly related to Mr Davison's death, we have not included it in our report.
5. We did not find any non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Davison's clinical care at HMP Holme House. The clinical review is attached to this report as Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Davison's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of our family liaison officers wrote to Mr Davison's next of kin, his mother, to explain the investigation. She asked for a copy of our report but raised no issues for investigation.
9. Mr Davison's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP Holme House

11. Mr Davison was the 15th prisoner to die at Holme House since May 2018. Of the previous deaths, nine were from natural causes, two were self-inflicted, two were drug-related and in one case, the cause of death was unascertained.

Key Events

12. On 16 January 2019, Mr Ian Davison was remanded in custody for fraud. He was sent to HMP Durham.
13. Mr Davison had been diagnosed with anal cancer in 2013, and had been treated with chemotherapy.
14. While Mr Davison was in prison his health gradually deteriorated and the prison GP suspected that his cancer had returned. The GP said that Mr Davison needed to be moved to a prison that could provide him with 24-hour healthcare. On 17 October, he was moved to HMP Holme House.
15. On 24 October, Mr Davison was escorted to hospital for a biopsy, and on 1 November, for a Positron Emission Tomography (PET) scan (an imaging test that helps reveal how the tissues and organs are functioning).
16. On 5 November, the results showed that Mr Davison's cancer had returned. Over the next two months, he was seen frequently at the hospital for further tests. Mr Davison was not offered any further treatment and received palliative care only.
17. On 29 January 2020, a prison GP discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Davison who agreed that if he stopped breathing he did not want to be resuscitated.
18. Over the next few months, Mr Davison's health deteriorated further. On 15 April, prison staff discussed early release on compassionate grounds with Mr Davison, who said that he did want to be considered for release.
19. On 21 April, it was agreed that Mr Davison could be released from prison on compassionate medical grounds. Because of his medical needs he would need to be released to a care home. The prison tried to find a suitable place for Mr Davison to be released to, but no suitable accommodation was found.
20. On 7 May at 7.22pm, healthcare staff went to Mr Davison's cell and found that he was not breathing and had no signs of life. There was no doctor in the prison to verify Mr Davison's death, so a paramedic was called. The paramedic arrived at the prison and confirmed that Mr Davison had died.
21. There was no post-mortem examination as the coroner accepted the cause of death provided by the paramedic. The paramedic gave the cause of death as anal squamous cell carcinoma (cancer of the anus).

Louise Richards
Assistant Ombudsman

September 2020

**Prisons &
Probation**

Ombudsman
Independent Investigations