Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Iain McDowall, a prisoner at HMP Haverigg, on 10 April 2023

A report by the Prisons and Probation Ombudsman

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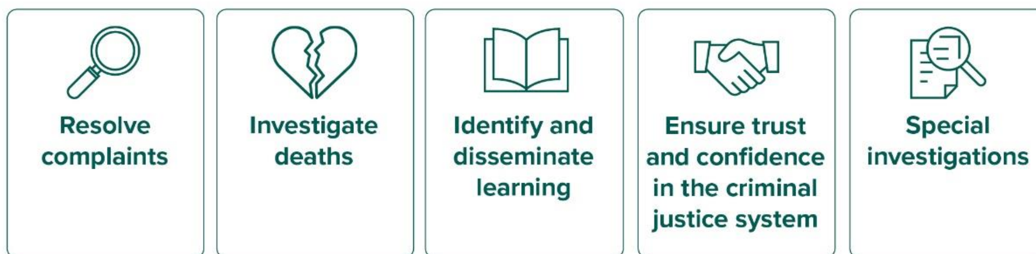
OUR VISION

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

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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 Iain McDowall died of sudden adult death syndrome on 10 April 2023 at HMP Haverigg. He was 51 years old. We offer our condolences to Mr McDowall's family and friends.

4. Mr McDowall collapsed while taking part in a 10km run at the prison. Staff responded quickly and started CPR, which was continued by paramedics. However, resuscitation attempts were unsuccessful.

5. Mr McDowall had no known medical conditions and had appeared fit and well prior to his collapse.

6. The clinical reviewer concluded that the clinical care Mr McDowall received at Haverigg was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that the emergency response was delivered very well. She made no recommendations.

7. We found no non-clinical issues of concern and make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr McDowall's death on 10 April 2023.

9. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. NHS England commissioned an independent clinical reviewer to review Mr McDowall's clinical care at Haverigg.

11. We informed HM Coroner for Cumbria of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The PPO family liaison officer wrote to Mr McDowall's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked what happened after Mr McDowall collapsed. This has been addressed in the report.

13. Mr McDowall's wife received a copy of the initial report. She did not make any comments.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Haverigg

15. Mr McDowall was the second prisoner to die at Haverigg since April 2020. The previous death was from natural causes.

Key Events

16. On 5 July 2019, Mr Iain McDowall was sentenced to ten years imprisonment for sexual offences.

17. Mr McDowall spent the next few years in closed category prisons. Throughout his time in custody, he attended his scheduled healthcare appointments and had standard NHS health checks, none of which identified any concerns.

18. On 11 March 2023, Mr McDowall was moved to HMP Haverigg, an open prison (low security prisons where prisoners have the freedom to leave the prison under certain conditions for resettlement purposes).

Events of 10 April

19. On 10 April at approximately 9.45am, Mr McDowall collapsed while taking part in an organised 10km run around the grounds of Haverigg. Race marshals alerted prison staff and at 9.46am, a prison officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The prison officer and a prison physical education instructor (PEI) took turns giving chest compressions while they waited for healthcare staff to arrive.

20. At 9.50am, two nurses arrived and helped the prison staff with chest compressions. A nurse attached a defibrillator (which shocks the heart to restore a normal heartbeat) to Mr McDowall, and it gave him one shock, which was unsuccessful. A GP from Haverigg also attended.

21. At 9.57am, paramedics arrived and gave Mr McDowall three doses of adrenaline, while prison staff continued to give chest compressions.

22. After approximately 20 minutes of trying to resuscitate Mr McDowall with no success, the GP and paramedics agreed to stop treatment and declared Mr McDowall deceased at 10.17am.

Post-mortem report

23. The post-mortem report concluded that Mr McDowall died of sudden adult death syndrome.

Adrian Usher
Prison and Probation Ombudsman **October 2023**

Inquest

24. The inquest, held on 7 December 2023, concluded that Mr McDowall died from natural causes.

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