

Private & Confidential

HM Senior Coroner Mid Kent and Medway
Mid Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

18th September 2025



Dear Sir/Madam,

Regulation 28 Report to Prevent Future Deaths – Inquest touching the death of Mr Azroy Dawes-Clarke

Thank you for your regulation 28 report to prevent future deaths dated 29th July 2025 following the inquest into the death of Mr Azroy Dawes-Clarke which concluded on 3rd July 2025.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Mr Dawes-Clarke's family and loved ones. Oxleas NHS Trust is keen to assure the family and the coroner that the concerns raised about Mr Dawes-Clarke's care have been listened to and acted upon. I appreciate that responses to Coroner Reports may constitute an important part of process through which family and friends come to terms with the passing of their loved one, and that this will have been an incredibly difficult time for them.

In section 5 of your letter, you raised concerns in relation to the care provided to Mr Dawes-Clarke namely:

(1) Despite the severity of the incident which occurred in this case, there had been little (if any) dialogue between leaders of the various parties involved. Formal complaint processes, safeguarding processes and risk reporting mechanisms had been used, but there was no discussion about how to learn from this specific case or how to avoid a reoccurrence. During prevention of future death evidence, responses were inconsistent as to how to avoid other difficulties during a major medical emergency in a prison setting. One suggestion made was that paramedics may not enter custodial settings in future but it was unclear how prison healthcare could replicate the skills had by the ambulance service (in particular, in the use of intraosseous access during initial resuscitation, or the skill sets of a critical care

paramedic or an advance trauma team which may be delivered by a helicopter emergency medical service).

(2) Despite the severity of the incident which occurred in this case, it appeared that there still remains confusion as to which public body would have primacy in an acute medical emergency in a custodial setting.

Following the inquest, senior leaders from Oxleas NHS Foundation Trust have considered these helpful observations and have responded to each of your concerns as follows:

(1) Despite the severity of the incident which occurred in this case, there had been little (if any) dialogue between leaders of the various parties involved. Formal complaint processes, safeguarding processes and risk reporting mechanisms had been used, but there was no discussion about how to learn from this specific case or how to avoid a reoccurrence. During prevention of future death evidence, responses were inconsistent as to how to avoid other difficulties during a major medical emergency in a prison setting. One suggestion made was that paramedics may not enter custodial settings in future but it was unclear how prison healthcare could replicate the skills had by the ambulance service (in particular, in the use of intraosseous access during initial resuscitation, or the skill sets of a critical care paramedic or an advance trauma team which may be delivered by a helicopter emergency medical service).

The concerns regarding dialogue and partnership working have been addressed. Since 2024, Oxleas, SECAMbs, and HMPPS have established a regular partnership meeting, bringing together leaders from agencies across Medway and Swale on a quarterly basis. The primary objectives of this collaboration are to review joint learning opportunities, share training resources, assess the impact of community NHS resources within the prison environment, and coordinate efforts to prepare for potential major incidents. The suggestion that prison healthcare staff could undertake the role of the ambulance service was not supported as this model is not in line with national commissioning policy however the underlying concerns regarding difficulties related to medical emergencies has been central to the partnership working and collaboration that has taken place.

As part of this collaboration, bronze, silver, and gold command training is being incorporated into the Oxleas service and is currently in the process of being sourced appropriately. Additionally, a memorandum of understanding is being jointly drafted by HMPPS, Kent Fire and Rescue, Oxleas, and SECAMbs to outline each agency's responsibilities and to facilitate coordinated joint working during major incidents.

A student paramedic placement has been initiated, with SECAMB seconded student paramedics spending one day at Sheppey prisons to become familiar with the environment. Insights shared during partnership meetings indicated that SECAMB personnel often find the prison setting challenging. Paramedic recruitment is ongoing at HMP Swaleside, and the initial one-day placement will be developed into comprehensive placements for student paramedics.

(2) Despite the severity of the incident which occurred in this case, it appeared that there still remains confusion as to which public body would have primacy in an acute medical emergency in a custodial setting.

It is recognised that in this very sad incident there may have been confusion regarding primacy in a medical emergency. This incident pre-dates Oxleas NHS Foundation Trust's delivery of healthcare services at HMP Elmley. The Trust is clear that, as the primary healthcare provider at HMP Elmley, Oxleas NHS Foundation Trust retains responsibility for the care and treatment of prisoners until their departure from custody, regardless of whether this occurs via ambulance or other means, including primacy in an acute medical emergency. There is an inpatient healthcare team at HMP Elmley and staff attend and lead healthcare emergencies as normal practice. Where paramedic support is required, our staff work with paramedics to ensure that their skills are deployed in partnership with the Oxleas staff during the incident.

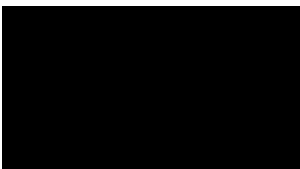
To promote comprehensive understanding of policies, a new Practice Development Nurse (PDN) joined our team in September 2024 to ensure that all healthcare staff remain current with relevant training and guidance.

The Quality Manager has recently conducted a comprehensive review of all policies, ensured they are updated to the latest versions, and communicated their locations to all staff members. The Practice Development Nurse (PDN) is responsible for ensuring that the healthcare team is informed about all relevant policies, comprehends their content and significance, and that these policies are consistently shared and discussed during teaching sessions, handovers, and supervision meetings. Training records will be maintained as evidence of compliance and understanding.

I hope that this letter reassures you that Oxleas has been highly attentive to the findings of your investigation, and that concerted remedial action has been taken on all the areas you identified to prevent any similar future deaths.

Please do not hesitate to contact me if any clarification or further assurance is required.

Yours sincerely,



Chief Executive Officer

CC: Chief Operation Officer, 
Chief Nursing Officer, 