Kent and Medway Coroners' Service

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Telephone: [redacted]
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Date: 29 July 2025

Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

(1) The Secretary of State for Justice;
(2) The Secretary of State for Health and Social Care.

1. CORONER

I am Ian Brownhill, Assistant Coroner for Kent and Medway.

2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 26 November 2021 an investigation commenced into the death of Azroy DAWES-CLARKE. The investigation concluded at the end of the inquest on 11 July 2025. The jury returned a narrative conclusion which read:

"From hearing all the evidence presented to us, we conclude that Azroy Dawes-Clarke died from a combination of factors beginning with the compression of the neck via self-inflicted ligaturing. This was followed by a disproportionate use of force by prison officers during control and restraint which led to Mr Dawes-Clarke going limp. After restraint, there was insufficient action taken by prison staff and paramedics upon realising Mr Dawes-Clarke's cardiac and respiratory arrest. From the body-worn footage, it is evident that prison staff neglected to consider Mr Dawes-Clarke's head positioning and breathing throughout the restraint. The poor practice of applying handcuffs while Mr Dawes-Clarke was in a kneeling position more than minimally increased the risk of positional asphyxia."

The medical cause of death was determined to be:

1a Hypoxic ischaemic brain injury due to cardio-respiratory arrest in close temporal proximity to a period of third party restraint shortly after apparent seizure like activity following compression of the neck by a ligature

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Azroy Dawes-Clarke died at Medway Maritime Hospital on 10 November 2021. The jury who heard the case, recorded that, "*prior to the 10th November and on the day of Mr Dawes-Clarke's passing, there was a lack of communication between all parties involved with regards to Mr Dawes-Clarke's physical and mental health."* Mr Dawes-Clarke had ligatured in both the houseblock, and in the separation and care unit of HMP Elmley, prior to the date of his death.

A decision was made to move Mr Dawes-Clarke to the inpatient department of HMP Elmley. Mr Dawes-Clarke was placed in a safer cell with no ligature points. He [redacted] applied a ligature to his neck, self-strangulating. The jury recorded, "*Mr Dawes-Clarke did not intend to end his own life when he used the ligature on the 10th November. Rather, ligaturing was a known coping mechanism of Mr Dawes-Clarke, which he would use in order to be listened to.*"

A member of healthcare staff saw him self-strangulating. Officers entered the cell and removed the ligature. A, "code blue" was called, which automatically caused an ambulance to be called to the prison. Prison healthcare staff, including two general practitioners working within the prison at the time were able to attend the cell and stabilise Mr Dawes-Clarke.

Paramedics attended the inpatient department and made the decision to convey Mr Dawes-Clarke to hospital. The prison healthcare staff, including the general practitioners then left the area. The general

practitioners provided a handover to the paramedics and left the prison it being the end of their shift and nobody asking them to stay.

Mr Dawes-Clarke had been wearing an anti-ligature gown. This left him exposed, a decision was made to clothe him. Whilst efforts were made to clothe Mr Dawes-Clarke, it was suggested that he had kicked one of the paramedics, who then left the cell. The jury went on to record:

"For Mr Dawes-Clarke's conveyance to hospital, it was appropriate to attempt to clothe him. However, it was inappropriate to persevere with clothing attempts. The decision making model should have been utilised, and attempts to clothe him should have stopped at the point of resistance.

Following the initiation of restraint against Mr Dawes-Clarke, the continued restraint escalated unnecessarily. The prolonged restraint of Mr Dawes-Clarke was inappropriate and disproportionate."

During the restraint of Mr Dawes-Clarke, the paramedics were not in the cell. Prison healthcare were not in the cell either. The jury recorded:

"The considerable delay in contacting healthcare to attend throughout the restraint, and furthermore the delay in raising the general alarm caused a significant hindrance. Prison officers were not able to receive vital medical advice for carrying out the restraint. This demonstrates that the lack of healthcare throughout the restraint was a failure and not in line with prison guidance.

The ability of the paramedics to perform their duty of care to Mr Dawes-Clarke during the restraint was limited by their placement and lack of visibility from outside the cell. Furthermore, it was inappropriate for the paramedics to approve the handcuffing of Mr Dawes-Clarke having had no training in mechanical restraint to give such advice."

Mr Dawes-Clarke was handcuffed (something which the jury found to be inappropriate considering his positioning) and he went limp and became unresponsive. Mr Dawes-Clarke had a cardiac and respiratory arrest. The jury went on to record:

"There were significant shortcomings from both the paramedics and prison officers in attendance in their responses to Mr Dawes-Clarke going limp and unresponsive. Specifically, the delay in establishing whether he was breathing and the inaction and further delay when starting CPR.

Throughout the whole incident, there was a failure on all parts to communicate effectively and properly. This includes the way in which emergency calls have to be relayed through the communications systems in prison."

Paramedics did re-enter the cell after a member of prison healthcare (a registered general nurse) attended. Treatment was given and there was a return of spontaneous circulation. Mr Dawes-Clarke was conveyed to Medway Maritime Hospital, having arrested again whilst being taken there. In the emergency department he became asystole and despite efforts at treating him, he died there.

The jury found that, *"the level of understanding and care from the prison staff was grossly insufficient."*

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) As the jury noted, communication between attending prison staff, healthcare professionals and paramedics was confused. There was confusion as to who had command and control of the medical emergency, which public body took primacy and the difference in roles and responsibilities. Those attending the scene did not establish any sort of communication strategy or command structure. During prevention of future deaths evidence, there remained a lack of clarity and consistency as to how such a situation would be avoided if a critical medical emergency eventuated in a custodial setting again.

(2)

(3)

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you as the Secretaries of State for Justice, Health and Social Care have the power to take such action.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 September 2025. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following interested persons in the inquest touching upon the death of Azroy Dawes-Clarke. I have also sent it to the following who may find it useful or of interest:

(i) The Chair of the Association of Ambulance Chief Executives;

(ii) The Chair of the Prison Governors Association; and

(iii) The Chief Executive Officer of NHS England.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

29 July 2025

Ian Brownhill

Assistant Coroner for Kent and Medway