

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Allison, a prisoner at HMP Holme House, on 25 April 2021

A report by the Prisons and Probation Ombudsman

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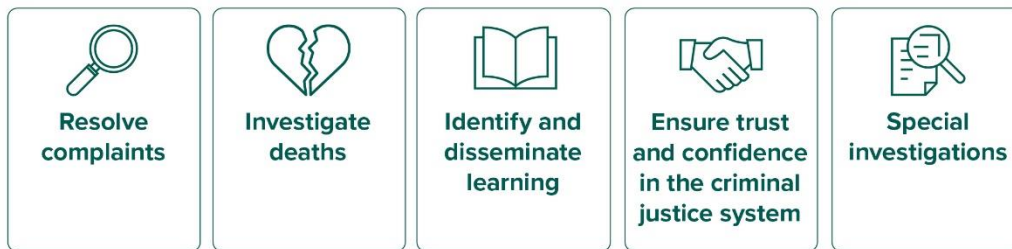
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OUR VISION

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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Raymond Allison died on 25 April 2021 from heart disease at HMP Holme House. He was 47 years old. I offer my condolences to Mr Allison's family and friends.

Mr Allison had no known heart issues and did not report any physical health concerns during his time at Holme House. The clinical reviewer was satisfied that the care he received was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberly Bingham
Acting Prisons and Probation Ombudsman

October 2022

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Summary

Events

1. Mr Raymond Allison was remanded to HMP Holme House in November 2016, charged with grievous bodily harm. He was subsequently sentenced to eight years imprisonment.
2. Mr Allison reported no physical health concerns while he was at Holme House.
3. On 25 April 2021, prisoners saw that Mr Allison and his cellmate were lying on the floor of their cell. A prisoner alerted officers who responded immediately and found Mr Allison unresponsive and his cellmate conscious but unable to walk or talk. Staff suspected that they had taken psychoactive substances (PS).
4. Officers called a medical emergency code; control room staff called an ambulance and healthcare staff attended. However, neither healthcare staff nor ambulance paramedics were able to resuscitate Mr Allison and he was pronounced dead at 3.19pm.
5. A post-mortem found that Mr Allison died from heart disease. Toxicology tests found no trace of PS.

Findings

6. Mr Allison had no physical healthcare concerns so was never seen by the primary care team at Holme House. His age meant that he would not have had any cardiac risk assessments undertaken. The clinical reviewer concluded that Mr Allison's clinical care at Holme House was equivalent to that which he could have expected to receive in the community.
7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Allison's death on 25 April 2021.
9. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her.
10. The investigator obtained copies of relevant extracts from Mr Allison's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Allison's clinical care at the prison. The investigator and clinical reviewer jointly interviewed seven members of staff on 28 July and 2 August 2021. The investigator interviewed one member of staff separately on 2 August 2021.
12. We informed HM Coroner for Teesside of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Allison's next of kin, his sister, to explain the investigation and to ask if she had any matters, she wanted us to consider. She asked how long it was before Mr Allison was found, which we have covered in this report. She raised some other issues about illicit drug taking at the prison but as Mr Allison's death was not drug-related, we have not addressed these.
14. Mr Allison'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.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Holme House

16. HMP Holme House is a category C training and resettlement prison holding a maximum of 1159 prisoners. Spectrum provides health services at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Holme House was in February 2020. Inspectors reported that there was a range of nurse-led clinics, and patients with long-term conditions or complex needs were monitored and reviewed appropriately. Although there was no lead nurse for long-term conditions, two senior nurses were undertaking training to take on this role. Health services staff liaised with the GP and external specialists to ensure a coordinated approach.
18. Arrangements for dealing with medical emergencies were comprehensive, and further enhanced by the addition of a paramedic to the team since the previous inspection. Registered clinical staff were trained in immediate life support and had access to suitable and regularly checked equipment. Officers were familiar with the emergency code protocol, and ambulances were called promptly in an emergency.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2021, the IMB reported that general healthcare services had improved, with the introduction of a community (houseblock-based) model. GP waiting lists were reduced as some consultations were held by telephone and houseblock-based nurses carried out triage.

Previous deaths at HMP Holme House

20. Mr Allison was the sixteenth prisoner to die at Holme House since April 2019. Of the previous deaths, 11 were from natural causes, three were self-inflicted and one awaits classification.

Key Events

21. On 3 November 2016, Mr Raymond Allison was remanded in prison custody, charged with grievous bodily harm, and sent to HMP Holme House. He was subsequently sentenced to eight years imprisonment.
22. When Mr Allison arrived at Holme House, a nurse carried out a reception health screen. She had no concerns about Mr Allison's physical or mental health, but noted that he used drugs, including heroin. Staff put him on a methadone (heroin substitute) programme.
23. Records show that Mr Allison was seen under the influence of drugs on numerous occasions at Holme House.

Events of 25 April 2021

24. On 25 April 2021, at 12.08pm, an officer locked Mr Allison and his cellmate in their cell.
25. CCTV shows that from 2.20pm onwards, various prisoners went to Mr Allison's cell and looked through the observation panel. The prisoners appeared to indicate to each other that something was wrong.
26. At 2.40pm, a wing cleaner looked through the observation panel and summoned another prisoner to have a look. The prisoner said he saw the cellmate on the floor. He shouted to him, but the cellmate seemed not to know where he was. Mr Allison was also on the floor. His arms were by his side and 'black and blue'. The prisoner ran to the other end of the wing and raised the alarm with Officer A.
27. Officer A reached Mr Allison's cell first, followed by other officers. Officer A looked into the cell. He saw Mr Allison lying on his front and the cell floor was covered in vomit. He immediately called a code blue (at 2.43pm) and he and Officer B entered the cell.
28. The officers could not get a response from Mr Allison. Officer B checked for a pulse in his neck but was unsure if what he could feel was his own or Mr Allison's. Officer B made another radio call for medical assistance (time not recorded) and helped Officer A put Mr Allison in the recovery position. Wing staff had brought an oxygen cannister to the cell just as healthcare staff arrived.
29. Within a few minutes of the code being called, a nurse and a support worker arrived. The nurse asked officers to turn Mr Allison on his back and she checked for a pulse but could not find one. The support worker started cardiopulmonary resuscitation (CPR) with the nurse. The support worker applied a defibrillator which Officer B had collected from the wing office. The defibrillator advised no shock.
30. During this time, the cellmate, who was conscious, was removed from the cell and treated by other healthcare staff.

31. Either the nurse or the support worker asked Officer B to fetch more oxygen as she realised, they would soon run low because the cylinders are small, portable ones which do not last long (approximately 20 minutes) and they were treating two patients at once. The officer located a cylinder on Houseblock 6 and DART support worker brought one from the Inpatients Department.
32. At 2.52pm, paramedics arrived at the prison and were at the cell a few minutes later. Resuscitation attempts were unsuccessful, and paramedics pronounced Mr Allison's death at 3.19pm.

Contact with Mr Allison's family.

33. On 25 April, the prison appointed a prison officer as the family liaison officer (FLO). While the FLO and colleagues were considering the next of kin information and availability of transport, two of Mr Allison's relatives arrived at the prison having been alerted via Facebook that something had happened to Mr Allison. The FLO broke the news of Mr Allison's death and maintained contact with the family over the following weeks.
34. Mr Allison's funeral was held in May and the prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

35. After Mr Allison's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Mr Allison's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Allison's death.

Post-mortem report

37. The post-mortem report concluded that Mr Allison died from ischaemic heart disease (narrowing of the arteries that supply the heart) caused by coronary artery atheroma (fatty deposits on the walls of the arteries) and left ventricular hypertrophy (where part of the heart has thickened and no longer pumps properly).
38. Although Mr Allison's cellmate allegedly said that he and Mr Allison had used psychoactive substances (PS – also known as 'Spice') before they both collapsed on 25 April, toxicology tests did not detect any PS in Mr Allison's system. The pathologist acknowledged that current testing techniques may not detect all variations of PS.
39. The toxicology tests also found therapeutic levels of methadone, mirtazapine and pregabalin. The toxicologist noted that this combination of drugs could cause central nervous system (brain) depression. However, the pathologist was satisfied that, given the low doses, these drugs did not cause Mr Allison's death. He was satisfied that Mr Allison had sufficient heart disease to explain his death.

Findings

Clinical care

40. Mr Allison had no physical health concerns, so he was not seen by the primary care team at Holme House. Due to his age, he would not have had any cardiac risk factor assessments undertaken such as Q-risk. (Q-risk is a prediction algorithm for cardiovascular disease.)
41. The clinical reviewer concluded that Mr Allison's clinical care was equivalent to that which he could have expected to receive in the community.
42. We make no recommendations.

Inquest

43. The inquest, held on 15 July 2024, concluded that a combination of the use of 'Spice' and underlying heart disease were the cause of Mr Allison's death.

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