Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Hayes, a prisoner at HMP High Down, on 1 January 2025

A report by the Prisons and Probation Ombudsman

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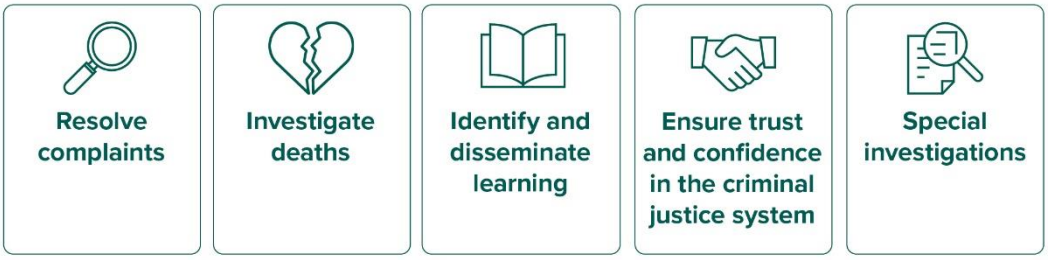
OUR VISION

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

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. On 8 September 2023, Mr Brian Hayes was sentenced to 18 years in prison for sexual offences. He was initially sent to HMP Wormwood Scrubs before being transferred to HMP High Down on 14 August 2024.

4. Mr Hayes died due to advanced Chronic Obstructive Pulmonary Disease (COPD, a progressive lung condition that makes it hard to breathe) on 1 January 2025. He was 56 years old. We offer our condolences to Mr Hayes' family and friends.

5. Mr Hayes did not name a next of kin and none could be identified following his death.

6. The PPO investigator investigated the non-clinical issues relating to Mr Hayes' care. We did not find any non-clinical issues of concern.

7. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Hayes received at High Down. The clinical reviewer concluded that the clinical care Mr Hayes received at High Down was of a good standard and at least equivalent to that which would have been received in wider community.

8. The clinical reviewer noted that Mr Hayes arrived in prison with end-stage COPD. He had regular reviews and the clinical reviewer found that the management of Mr Hayes' COPD was in line with national guidelines.

9. Mr Hayes had a do not attempt CPR (DNACPR) order and an advanced care plan, which the clinical reviewer found was developed in conjunction with his wishes. However, the clinical reviewer found that local adoption of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) should be considered. This is a form developed by the Resuscitation Council UK to provide a structured approach to recording resuscitation decisions and advanced care planning, which the clinical reviewer noted can effectively communicate an individual's wishes to ambulance crews and treating clinicians if they cannot do so themselves.

   We make the following recommendation:

   The Head of Healthcare should review the current documentation process for DNACPR decisions and consider adopting the ReSPECT form.

10. The inquest into Mr Hayes' death concluded on 4 June 2025 and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

July 2025

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