

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Evans, a prisoner at HMP Stocken, on 24 November 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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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 12 December 2022, Mr John Evans was sentenced to 33 months in prison for possession of class A drugs with the intent to supply. On 27 June 2023, he was sentenced to a further nine months in prison for possession of class A drugs with the intent to supply.
4. Mr Evans died of ischaemic heart disease on 24 November 2023, at HMP Stocken. He was 50 years old. We offer our condolences to Mr Evans' family and friends.
5. The PPO family liaison officer wrote to Mr Evans' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
6. NHS England commissioned an independent clinical reviewer to review Mr Evans' clinical care at HMP Stocken.
7. The clinical reviewer concluded that the clinical care Mr Evans received at Stocken was of a good standard and equivalent to what he could have expected to receive in the community. She made three recommendations which are not directly linked to Mr Evans' cause of death, but which the Head of Healthcare and GP Lead will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Evans' care.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

June 2024

At the inquest held on 28 August 2024, the coroner concluded that Mr Evans died of natural causes.

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