Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Evans, a prisoner at HMP Ashfield, on 13 March 2023

A report by the Prisons and Probation Ombudsman

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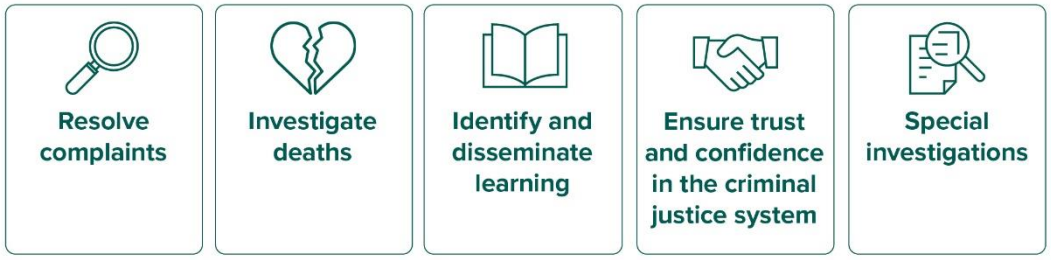
OUR VISION

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

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.

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.

Mr William Evans died in hospital from a heart attack on 13 March 2023, while a prisoner at HMP Ashfield. He was 72 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr Evans received at Ashfield was partially equivalent to that which he could have expected to receive in the community. She found that the care he received prior to 11 March 2023 was good, but that on that day, it fell below the standard reasonably expected as there was a delay in escalating treatment.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On 23 March 2018, Mr William Evans was sentenced to 15 years in prison. On 27 November 2019, he was moved to HMP Ashfield.

2. When Mr Evans arrived at Ashfield, it had already been identified that he was at high risk of a heart attack or stroke. Staff offered him statins (cholesterol-lowering medication) to reduce his risk, but he repeatedly refused them as he said they gave him side effects.

3. Mr Evans experienced some chest pains in early 2022. He was referred to hospital for tests, but they found nothing of concern.

4. Shortly before 5.00am on 11 March, Mr Evans pressed his emergency cell bell as he was feeling unwell and finding it difficult to breathe. Officers attended and found the cell was very hot. They turned off the heater and increased the ventilation in the cell. They asked healthcare staff to see Mr Evans when they arrived at the prison (no healthcare staff are on duty overnight).

5. At around 11.30am, healthcare staff saw Mr Evans in his cell. Mr Evans complained of nausea and dizziness in the night, and ongoing issues of pins and needles in his arm, constipation and a frequent need to urinate. He did not mention chest pains. Healthcare staff took his clinical observations which were all within normal ranges. They told Mr Evans to call for help if he felt worse.

6. Officers checked on Mr Evans throughout the day. He remained unwell and did not eat, but as he did not feel worse during the day and evening, staff did not call for healthcare staff.

7. When Mr Evans was unlocked at around 8.30am on 12 March, he was still feeling unwell, so officers called for a nurse to see him. She found that some of Mr Evans' clinical observations were abnormal, and she asked an officer to call a medical emergency code. An ambulance arrived at 9.30am. Paramedics assessed that Mr Evans might be having a heart attack and that he needed to go to hospital.

8. On the way to hospital, Mr Evans suffered a heart attack in the ambulance. He was admitted to hospital but died there the next day.

Findings

9. The clinical reviewer found that the care Mr Evans received up to 11 March 2023 was of a good standard. Staff had tried to persuade Mr Evans to take statins and explained the risks of not doing so. Despite this, there were long periods when Mr Evans did not take his medication.

10. The clinical reviewer found that the care Mr Evans received on 11 March, fell below the standard reasonably expected and was not equivalent to that which he could have expected to receive in the community. She found no evidence that the healthcare staff who saw Mr Evans on 11 March had checked his medical history

before seeing him, or that they had asked him about it. She considered that the assessment did not take into account Mr Evans' high risk of heart attack and there were missed opportunities to escalate his care.

Recommendations

- The Head of Healthcare should ensure that when healthcare staff undertake clinical assessments of acutely unwell patients, they complete a comprehensive assessment that includes obtaining a patient's past medical history to inform a safe and comprehensive ongoing clinical treatment plan.

The Investigation Process

11. HMPPS notified us of Mr Evans' death on 13 March 2022.

12. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Evans' prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Evans' clinical care at the prison.

15. The investigator and clinical reviewer interviewed two Ashfield healthcare staff on 1 June, and the investigator interviewed two Ashfield prison officers on 5 June. All interviews were carried out by video call.

16. We informed HM Coroner for Avon of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer wrote to Mr Evans' son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Ashfield

19. HMP Ashfield is a Category C prison, operated by Serco and holding approximately 400 men who have been convicted of sexual offences. Oxleas NHS Foundation Trust provide physical healthcare services during the day from 7.30am to 5.30pm. An out of hours service is available for other times.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Ashfield was in March 2019. Inspectors reported the health and social care provisions were of a good standard and most prisoners were satisfied with the quality of healthcare received. However, inspectors found that not all prisoners with long-term health conditions had care plans in place.

Independent Monitoring Board

21. 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 30 June 2022, the IMB found that although access to routine healthcare services was generally assessed as equal to that provided in the community, they were concerned that healthcare staff shortages could present a risk to the long-term health and wellbeing of prisoners.

Previous deaths at HMP Ashfield

22. Mr Evans was the seventh prisoner to die at Ashfield since March 2020. All the deaths were from natural causes. In one of these recent deaths, we were also concerned about a delay in escalating treatment. The healthcare provider has not yet responded to our recommendation.

Key Events

23. On 23 October 2017, a court ordered that Mr William Evans should be remanded to prison, pending the outcome of his charges of sexual offences. However, because of chest pains, Mr Evans was taken to hospital. Doctors found no issues of concern. They discharged him from hospital the next day and he was taken to prison.

24. On 23 March 2018, Mr Evans was sentenced to 15 years in prison. On 27 November 2019, he was moved to HMP Ashfield.

25. Mr Evans had been diagnosed with high cholesterol in the blood (which increases the risk of heart attack and stroke) before he arrived at Ashfield and had been prescribed statins (cholesterol-lowering medication). In May 2020, he said that he no longer wanted to take statins due to the side effects. Healthcare staff at Ashfield advised him of the risks of not taking the medication but he still refused.

26. In February 2021, a QRISK assessment (which calculates the likelihood of a stroke or heart attack in the next ten years) showed that Mr Evans was at high risk. He continued to refuse statins.

27. On 25 January 2022, Mr Evans complained of chest pains. Healthcare staff took his clinical observations which were normal. However, blood test results showed a potential heart problem. A GP at Ashfield told Mr Evans that he needed to go to hospital, but Mr Evans said he felt fine and did not want to go to hospital. He again refused statins. He said that he had tried them before and felt better without them.

28. The GP referred Mr Evans to a hospital rapid access chest clinic, and a cardiac nurse specialist saw Mr Evans on 15 March. Mr Evans said that he had experienced chest pain three times in the last three months. He said this occurred at rest and lasted for about 10-20 seconds and felt like someone poking him inside his chest. However, there were no significant abnormalities detected and the nurse discussed Mr Evans with the consultant cardiologist who considered that Mr Evans' symptoms were not heart related. They suggested that Mr Evans should take statin medication.

29. In June, a GP at Ashfield persuaded Mr Evans to try statins but once again he complained of side effects and stopped taking them in July.

30. In September, a GP at Ashfield persuaded Mr Evans to try a different statin. Once again, he complained of side effects but remained on the medication and was still taking it in March 2023. Besides collecting his statin medication, in the weeks prior to 11 March, Mr Evans had no physical complaints and had very little contact with healthcare staff.

Events of 11-13 March

31. Shortly before 5.00am on 11 March, Mr Evans pressed his emergency cell bell. He said that something was happening to him, but he did not know what, and that he was sweating and finding it difficult to breathe. The Duty Custodial Operational Manager (COM) and two officers went to Mr Evans' cell which was very hot (staff told the investigator that it usually was). An officer said they opened up vents, which

Mr Evans had blocked, and turned off a heater, and that after a while Mr Evans said that he felt better. The officers left Mr Evans in his cell and checked on him again after around 15 minutes. Mr Evans said he felt much better. The officers told Mr Evans that they would let healthcare staff know when they arrived that morning, so that they could visit him.

32. At about 10.00am, Mr Evans made a phone call to a friend. He said that he felt very unwell and was phoning in case anything happened to him. He said he had also notified his solicitor. He said that he had a chest pain that felt like he had a weight on his chest, and that he felt very disorientated and weak.

33. At around 11.30am, the Head of Healthcare (who was carrying out a nurse shift that day) and a nurse saw Mr Evans in his cell. The Head of Healthcare said that officers had told her about the events earlier that morning, but that when she saw Mr Evans, he did not mention any chest pain. He complained of dizziness and nausea in the night, and recent constipation and a frequent need to urinate. Mr Evans said he had pins and needles in his arm, but he thought this related to a long-term issue with a trapped nerve. He thought some of his other symptoms were side effects of his statin medication. The Head of Healthcare took Mr Evans' clinical observations which were all normal.

34. At interview, the Head of Healthcare said that as all Mr Evans' clinical observations were normal, she would have advised him to contact an officer if he had any further problems. She arranged for a GP to review Mr Evans and his medication in a routine appointment. The wing logbook records that the healthcare staff told the officers that Mr Evans would need to go over to the pharmacy to pick up some paracetamol.

35. At interview, an officer who was on the wing during the day told us that they checked on Mr Evans every now and then to see how he was. Mr Evans did not want to come out of his cell and refused all offers of food that day. The officer said that Mr Evans thought that he had food poisoning. They also said that the advice from healthcare was to contact them again if Mr Evans got any worse, and although Mr Evans did not get better, he did not get any worse during the officer's shift. The officer said that Mr Evans did not mention chest pains at all.

36. The night officer who had responded to Mr Evans' call at around 5.00am, was back on duty that night. He said that at the beginning of his shift he went to see Mr Evans, who told him that he felt better. The officer advised him to press his cell bell in the night if he needed to.

37. At around 8.30am the next morning, when an officer unlocked Mr Evans' cell, Mr Evans said that he felt very unwell. He again told the officer that he thought he had food poisoning. The officer consulted with his colleague who had seen Mr Evans the day before. He then reported this to a nurse, who had also seen Mr Evans the day before, and she advised that Mr Evans should get some fresh air. The officers were concerned about Mr Evans and suggested that he should be seen as soon as possible.

38. Shortly after the call from the officer, the nurse went to Mr Evans' cell to check on him. She said at interview that his physical presentation was not immediately concerning as he was alert and appeared to be breathing without too much

difficulty, but when she carried out clinical observations on him, his blood pressure, heart rate and blood oxygen levels were all below normal limits and generated a National Early Warning Score (NEWS2) of 7. (NEWS2 is a tool for assessing clinical deterioration. It allocates a score of 0-3 for each vital sign: respiratory rate; blood oxygen level; pulse; blood pressure; temperature and level of consciousness. The scores are added together, and the higher the score, the greater the risk and need for escalation of care. A NEWS2 rating of 7 is high and indicates an urgent clinical assessment is required.)

39. At around 9.00am, the nurse asked one of the officers to call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance). At 9.06am, the control room called for an ambulance, which arrived at the prison at around 9.30am.

40. Paramedics took Mr Evans to the hospital, and on the way, one of the prison escort staff reported that paramedics suspected that Mr Evans had a heart attack in the back of the ambulance. Doctors at the hospital discovered that Mr Evans had severe damage to his heart and also had kidney failure.

41. Doctors were unable to treat Mr Evans and he died in hospital the next day, on 13 March.

Contact with Mr Evans' family

42. The prison appointed a family liaison officer (FLO) very soon after Mr Evans was taken to hospital on 12 March. The FLO contacted Mr Evans' son soon after that, and he was able to visit his father in hospital the same day. Following Mr Evans' death, the FLO maintained contact with his son and coordinated funeral arrangements with him and the return of his father's property. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

43. After Mr Evans' death, staff were offered support, and the prisoners on the wing were called together and managers explained that Mr Evans had died. Subsequently both the prison chaplaincy and Safer Custody staff were on hand for prisoners if they wanted support.

Cause of death

44. The Coroner told us that Mr Evans died from a myocardial infarction (heart attack). There was no post-mortem examination.

Findings

Clinical care

45. Mr Evans was identified as being at high risk of heart attack and stroke. The clinical reviewer found plenty of evidence that healthcare staff at Ashfield had tried to encourage Mr Evans to take statins to lower his risk of heart attack and stroke, but he repeatedly refused. There were no concerns about Mr Evans' understanding of the risks of not taking his medication, so this was his personal decision, which staff had to respect. The clinical reviewer found that the care Mr Evans received up to 11 March 2023 was of a good standard.

46. The clinical reviewer found that the care Mr Evans received at Ashfield on 11 March was not of the expected standard. She noted that when the Head of Healthcare and a nurse saw Mr Evans in his cell on 11 March, neither of them were familiar with him and neither had looked at his medical records. There is also no evidence that they asked him about his medical history, though the Head of Healthcare told the clinical reviewer that she would have checked this when she made the entry in Mr Evans' medical record following the visit. The clinical reviewer noted that had this visit occurred on a weekday rather than a Saturday, Mr Evans would have attended the healthcare unit, where his medical record would have been more easily accessible.

47. The clinical reviewer was concerned that Mr Evans' symptoms of chest pain, pins and needles and urinary frequency, were not seen in the context of his high risk of heart attack (though she noted that Mr Evans did not complain of chest pain by the time the Head of Healthcare saw him). She noted that the clinical observations were normal but pointed out that early symptoms of a heart attack are not identified through abnormal clinical observations. She also noted that both the Head of Healthcare and nurse who saw Mr Evans on 11 March did not consider that he presented as though he was having a heart attack as he was not short of breath. However, she considered, on balance, that the assessment of Mr Evans could have been more thorough, with reference to his medical history.

48. We recommend:

    The Head of Healthcare should ensure that when healthcare staff undertake clinical assessments of acutely unwell patients, they complete a comprehensive assessment that includes obtaining a patient's past medical history to inform a safe and comprehensive ongoing clinical treatment plan.

Note to Governor

Emergency response

49. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that when a medical emergency code is called, staff in the control/communications room should call an ambulance immediately. It says, '...the member of staff using the medical emergency code must also provide relevant

information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process'.

50. On 12 March, the code blue was called at 9.00am but the call to the ambulance service was not made until 9.06am. It became apparent during interviews that there was a little confusion about whether the code blue was called initially so that the nurse could get a second opinion from another member of healthcare staff (after healthcare staff had not responded to an initial call for healthcare staff to attend). However, whenever a code blue is called, the control room should call for an ambulance immediately. The call should not be delayed in order to get relevant information from staff at the scene, and certainly not for six minutes.

51. We make no recommendation, but the Director may wish to consider the learning from this case.

Inquest

52. The inquest, held on 21 October 2024, concluded that Mr Evans died from natural causes.

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