Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sion Evans, a prisoner at HMP Parc, on 12 August 2022

A report by the Prisons and Probation Ombudsman

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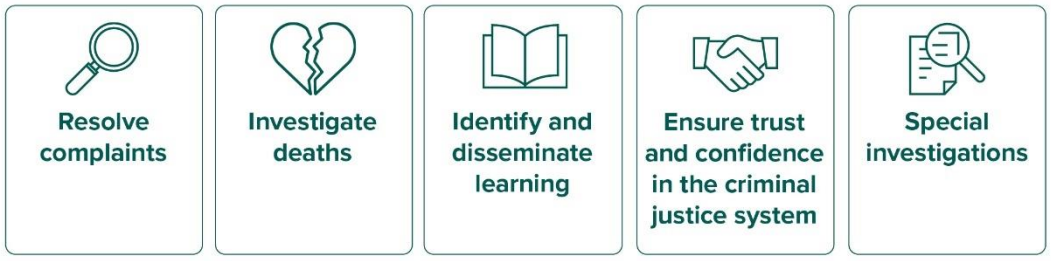
OUR VISION

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.

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 Sion Evans died on 12 August 2022, after he was found unresponsive with a ligature around his neck in his cell at HMP Parc. He was 38 years old. I offer my condolences to Mr Evans' family and friends.

Mr Evans arrived at Parc on 8 April 2022. It was his first time in prison. He had a history of mental health issues and staff supported him using suicide and self-harm prevention procedures (known as ACCT) as soon as he arrived. Mr Evans was moved to the Safer Custody Unit on 10 May, when staff became concerned about his behaviour and deteriorating mental health. He was moved back to a standard wing on 6 July, when he appeared more settled, and on 15 July, staff stopped ACCT monitoring.

Mr Evans met his solicitor on 11 August, the day before he died. We were unable to confirm the content of their discussion, but after Mr Evans died, prisoners said he was worried he would get a long sentence.

My investigation found that the ACCT procedures were broadly managed well. The decision to close the ACCT on 15 July was a reasonable one in the circumstances, as was the decision to keep the ACCT closed at the post-closure review on 22 July. There was no indication that Mr Evans was at imminent risk of suicide at that time.

Mr Evans was referred for a mental health assessment on 9 April but was not seen until 7 May, which was a far longer timescale than that expected in the community. The clinical reviewer also found that healthcare staff should have considered a referral to a psychiatric hospital given that, in his view, Mr Evans was presenting with a severe mental illness during his time in the Safer Custody Unit.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. On 8 April 2022, Mr Sion Evans was remanded in prison custody at HMP Parc, charged with serious sexual offences. Mr Evans had attempted suicide two weeks before and so prison staff started suicide and self-harm monitoring (known as ACCT) when he arrived.

2. On 10 May, staff moved Mr Evans to the Safer Custody Unit (SCU), as they were concerned about his erratic behaviour and deteriorating mental health. While in the SCU, Mr Evans' erratic behaviour continued, and he smeared urine, faeces and semen on the walls of his cell. He also lost a significant amount of weight.

3. Towards the end of June, Mr Evans' behaviour improved and on 6 July, he was moved back to a standard wing. On 15 July, staff stopped ACCT monitoring. At the post-closure review a week later, staff kept the ACCT closed.

4. Mr Evans met his solicitor on 11 August. We have been unable to confirm what they discussed but, after Mr Evans' death, prisoners said that Mr Evans was worried he would get a long sentence.

5. At 9.56am, after Mr Evans had failed to attend work, an officer went to his cell and found him on the floor with a ligature around his neck attached to a chair. Staff and paramedics tried to resuscitate him but were unsuccessful. At 10.52am, ambulance paramedics pronounced that Mr Evans had died.

Findings

6. We found that the decision to stop ACCT monitoring on 15 July, and the decision to keep the ACCT closed at the post-closure review a week later, were reasonable in the circumstances. There was no indication that Mr Evans was at imminent risk of suicide at that time. We found that the ACCT procedures were broadly managed well but there were too many case reviews with only one member of staff present and no healthcare staff.

7. The clinical reviewer found that aspects of Mr Evans' care were not equivalent to that which he could have expected to receive in the community. Staff referred Mr Evans for a mental health assessment on 9 April, but he was not seen until 7 May. The clinical reviewer considered this was a long delay and was not the standard that would be expected in the community. He also considered that healthcare staff should have considered a referral to a psychiatric hospital when in his view, Mr Evans was showing symptoms of a severe mental illness.

8. The clinical reviewer was also concerned that Mr Evans, who was severely short sighted, went for weeks without his glasses or contact lenses, and was never seen by the optician while he was at Parc.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with policy, and in particular, staff should:
    - ensure relevant staff involved in the prisoner's care, including healthcare staff where appropriate, are invited to all case reviews; and
    - involve a prisoner's next-of-kin in the ACCT process when appropriate.
- The Head of Healthcare should ensure there is an effective system for urgent mental health referrals to be tracked and carried out within a reasonable timescale.
- The Director and Head of Healthcare should ensure that if staff notice that a prisoner has lost a significant amount of weight, they refer them to a medical professional who can assess them for possible causes.
- The Head of Healthcare should ensure that prisoners who appear acutely, psychiatrically unwell are considered for transfer to a psychiatric hospital, and these discussions are recorded in the medical record.
- The Director and Head of Healthcare should ensure that:
    - corrective visual aids are made available as a priority to prisoners who need them for daily living activities; and
    - prisoners are seen by the optician within the timelines set out in their Service Level Agreement.

The Investigation Process

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

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

11. The investigator interviewed 11 members of staff in October, and November.

12. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Evans' clinical care at the prison. He jointly interviewed four healthcare staff.

13. We informed HM Coroner for South Wales Central of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Evans' mother, to explain the investigation and to ask if she had any matters she wanted us to consider. Her representatives responded with several questions, some of which were not within the remit of our investigation and will be answered in separate correspondence. The questions that will be covered were:

    - What was known about Mr Evans' risk of suicide and self-harm when he arrived at Parc?
    - What risk assessments were carried out?
    - Why was Mr Evans' ACCT closed prior to his death?
    - What psychiatric assessments did Mr Evans have in prison?
    - What diagnoses and treatment arose from his assessments?
    - Why did prison staff not contact Mr Evans' family about his mental health difficulties?
    - Why did staff not check Mr Evans' when he did not arrive at work?

15. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies, which are amended in this report.

16. We provided Mr Evans' next of kin with a copy of our initial report. They raised a number of issues that are addressed in separate correspondence.

Background Information

HMP Parc

17. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 adult and young adult men who are either on remand or convicted. It also has a unit for up to 60 young people under 18. G4S Medical Services provide primary physical and mental healthcare services. Secondary care mental health services are provided by Cwm Taff Morgannwg University Health Board. There is 24-hour general healthcare service. A local GP practice provides GP services, including a daily clinic and out of hours cover. Healthcare staff are on duty in the prison at night.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Parc was in June and July 2022. Inspectors reported that levels of self-harm remained too high among prisoners. A considerable number of prisoners were being supported through ACCT case management and many reported a good level of care from staff. However, the quality of ACCT care planning was not good enough.

19. Inspectors found the prison's Safer Custody Unit (SCU) provided special intervention and additional monitoring for prisoners who were mentally unwell. It provided a safe place for prisoners to interact, who might otherwise be isolated on a wing or the segregation unit.

20. Inspectors reported that the provision of mental health services at Parc was not good enough, particularly as the population had higher than average numbers of prisoners coming in with mental health difficulties.

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 28 February 2021, the IMB noted that levels of self-harm had increased. The optician's waiting list had become excessive due to restrictions on entering the prison during the pandemic.

Previous deaths at HMP Parc

22. Mr Evans was the fourteenth prisoner to die at Parc since August 2020. Of the previous deaths, ten were from natural causes, two were drug-related and in one, the cause of death was unascertained. There were no similarities between our findings in this investigation and our previous investigations.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk,

how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

25. On 8 April 2022, Mr Sion Evans was remanded in prison custody at HMP Parc, charged with rape, attempted rape, kidnap, false imprisonment and assault. It was his first time in prison.

26. Before arriving at Parc, Mr Evans had spent four days in a psychiatric hospital after being detained under Section 2 of the Mental Health Act (1983) following his arrest. Mr Evans was discharged to Parc without a formal diagnosis of mental illness. Hospital nurses thought Mr Evans' behaviours might be suggestive of bipolar disorder, but the assessing doctor thought it was more likely he had a narcissistic personality.

27. When Mr Evans arrived at Parc, his Person Escort Record (PER - a form that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) said that he had attempted suicide two weeks earlier while in the community. Staff started suicide and self-harm monitoring (known as ACCT) and checked Mr Evans twice an hour.

28. An Operational Manager (OM) chaired Mr Evans' first ACCT case review on 9 April. A Prison Custody Officer (PCO), the ACCT assessor, and a nurse attended, along with Mr Evans. The OM noted that Mr Evans seemed agitated and behaved bizarrely at times. He referred Mr Evans for a mental health assessment. Mr Evans asked for his glasses, which the nurse agreed to follow up. The review panel kept the ACCT open but reduced observations to one an hour. They noted that Mr Evans would remain in a camera cell (on X Block, a wing for vulnerable prisoners).

29. Also on 9 April, Mr Evans saw a representative from the Patient Advice Liaison Service (PALS). They discussed Mr Evans' recent mental health issues and his detention in the psychiatric hospital. The healthcare team had already referred Mr Evans for a mental health assessment and were in the process of acquiring his community healthcare records. Mr Evans then told a pharmacist he had been prescribed sertraline (an antidepressant) in the community. The pharmacist requested an urgent mental health review and contacted Mr Evans' GP, to confirm his prescribed medication. The GP confirmed that Mr Evans had been prescribed sertraline, which the prison re-prescribed on 11 April.

30. On 13 April, Mr Evans applied to see the optician, as he said he needed glasses because he was struggling to see. Mr Evans subsequently asked for his contact lenses on 25 April, which he said were in his stored property. (There was no evidence that Mr Evans had contact lenses or glasses in his stored property, but glasses were posted into the prison and handed to him on 27 April.)

31. An OM held case reviews with Mr Evans on 13, 19 and 25 April. Mr Evans was the only other person present each time. On 19 April, the OM noted that Mr Evans seemed more relaxed in himself and had come to terms with his remand status. She noted that Mr Evans' next court hearing was on 11 May, and he was hoping to get a new solicitor. On 25 April, the OM noted that Mr Evans had moved out of the camera cell, that he felt settled and safe on the wing and that he had spoken with his new solicitor. He said he was hoping for bail and said it would be 'soul crushing' if he did not get it.

32. An OM held a case review with Mr Evans on 2 May. No one else attended. The OM noted that although Mr Evans engaged, he was erratic and made no sense at times. Mr Evans said that if he did not speak to the police liaison officer, he would 'jump out of his cell window and start flying away'. He also said that his court case would not be going ahead on 11 May as he was able to 'stop time' and that he would be released by then anyway. The OM again referred him for a mental health assessment.

33. That evening, a nurse saw Mr Evans after wing staff expressed concerns about Mr Evans' mental state. As the prison was in night state, she spoke to Mr Evans through his cell door. Mr Evans said that someone needed to call the police as 'a female' had tried to kill him by stabbing him 22 times on 30 April (when talking about the female he pointed to the cell next door). He said that he was worried about being put in prison for a long time because the police had not considered all the information properly and that he was scared he would be killed by 'the people in this place'. He requested zopiclone to help him sleep, but she told him she could not get anyone to prescribe it at that time of night. She advised wing staff to increase ACCT observations to two an hour. She made another referral to the mental health team for assessment.

34. On 7 May, a nurse went to Mr Evans' cell to carry out a mental health assessment. He could not be unlocked, so she spoke to him through his cell door. She noted that Mr Evans was very animated, was laughing randomly and moving around his cell as she asked him questions. He said that the Samaritans were on the phone, and they had reported that they were MI5. Mr Evans remained on the mental health team's list for further assessment.

35. On 8 May, staff moved Mr Evans to a new cell after he smashed a chair. He also banged on his cell door and demanded to see the Queen. Staff moved him to a camera cell where wing staff could keep a closer eye on him due to his bizarre behaviour.

36. On 9 May, an OM held a case review with Mr Evans. No one else attended. When she asked Mr Evans about the events of the previous day, he said that he did not know why it had happened and then said there were many reasons. He said he had a panic attack as he felt trapped. She noted that Mr Evans' mental health was deteriorating, and that healthcare staff would be made aware.

37. On 10 May, a nurse went to Mr Evans' cell because wing staff had asked for a nurse to see him before they downgraded him to the basic regime of the Incentives and Earned Privileges (IEP) scheme. Mr Evans had barricaded the cell so nobody could enter, so she spoke to him through the cell door. She noted she had difficulty hearing Mr Evans above the noise of the wing, but she heard him ask to speak to Prince William at one point. She made an urgent mental health referral. She also noted that she had discussed moving Mr Evans to the Safer Custody Unit (SCU) to assess and monitor his risks.

38. Later that day, Mr Evans tried to assault a member of staff when they opened his cell door to give him his food. Staff restrained him and a nurse assessed Mr Evans afterwards. She noted that he appeared very timid, was sitting in the corner of his cell playing with his in-cell telephone and was unharmed. Staff decided to move him to the SCU.

Safer Custody Unit – 10 May to 6 July

39. Mr Evans was moved to the SCU on 10 May. He was placed in a camera cell so he could be monitored.

40. On 11 May, Mr Evans refused to attend his court videolink hearing, which was adjourned to 24 May. An OM tried to hold a case review with Mr Evans later that morning, but he would not engage. He had defecated on the floor of his cell and was blocking the door so that no one could enter.

41. On 12 May, two OMs tried to hold a case review, but Mr Evans refused to engage. He was displaying volatile behaviour and throwing water through and under the cell door.

42. On 13 May, staff noted that Mr Evans was naked in his cell and masturbating. He had smeared urine, faeces and semen over the cell walls. Staff arranged to move Mr Evans to a clean cell and left him food and water in there. When they went to move Mr Evans, he hit an officer, so staff had to use force to move him. He drank and ate in his new cell. Mr Evans returned to his original cell after staff had cleaned it.

43. A psychiatrist and an occupational therapist observed Mr Evans via the camera in his cell as part of the assessment process and so that they could begin to form a view on whether he had a mental disorder or was fabricating symptoms for some other reason. The psychiatrist advised staff to continue a period of monitoring before a review on Monday 16 May.

44. A nurse assessed Mr Evans on 16 May. She was unable to enter his cell because it was not considered safe to do so, so observed him on camera. She noted that he was pacing up and down with a pillow against his face. Staff said he had not slept much in five days but had been eating and drinking. She discussed Mr Evans with the pharmacist, who prescribed diazepam to help him sleep and reduce his agitation.

45. An OM held an ACCT review with Mr Evans on 16 May. A nurse attended. The OM noted that Mr Evans was still smearing faeces in his cell. He was initially incoherent and unwilling to engage but his engagement improved after he was given his diazepam.

46. On 18 May, a prison GP tried to assess Mr Evans' mental health, but she was unable to enter the cell so spoke to him through his cell door. She noted that when she asked him why he was smearing faeces on the walls, he started throwing faeces under the door and then refused to engage with her. She agreed he should continue to be prescribed diazepam until the psychiatrist assessed him again.

47. A nurse reviewed Mr Evans on 19 May. She noted that he engaged well, and he agreed to have a shower. He then went to another cell while his cell was cleaned. She noted that Mr Evans was struggling to see as he usually wore glasses (we do not know what had happened to the glasses handed to Mr Evans on 27 April, or whether they were no longer the correct prescription). She also noted that she had a bizarre conversation with him, including him saying that the faeces in his cell were not his and he had gone into the cell to clean it and then been locked in.

48. The SCU manager held a case review with Mr Evans on 23 May. A nurse, a prison chaplain and Mr Evans' key worker attended. Mr Evans engaged well but said he had done nothing wrong and did not know why he was in prison. He said he had no thoughts of suicide or self-harm.

49. The psychiatrist and a nurse assessed Mr Evans on 26 May. They noted that he engaged well and that officers had reported a positive change in his behaviour. They agreed that Mr Evans should remain on the SCU for the time being, and he should continue taking diazepam.

50. The SCU manager held a case review with Mr Evans on 30 May. The occupational therapist from the mental health team attended. Mr Evans said he felt frustrated at times but had no thoughts of suicide or self-harm. He said he had had a breakdown due to lack of sleep. He denied taking drugs. Mr Evans said he knew he would eventually have to move back to X Block, the vulnerable prisoners' wing, but was not yet ready.

51. The SCU manager and a nurse held a case review with Mr Evans on 6 June. Mr Evans said he did not want to be in a cell without a phone and asked about going back to X Block. He said he had no thoughts of suicide or self-harm. The manager told him that the nurses had to be happy with his mental health before moving him back. The review panel noted that they would discuss the possibility of relocating him.

52. A healthcare worker carried out a welfare check on 12 June. Mr Evans said he did not require any assistance with anything, he presented well, and he had cleaned and tidied his cell. A nurse weighed Mr Evans later the same day. She noted he had lost 12kg in ten weeks and was now clinically underweight. She noted that his weight would be monitored. Staff held a case review the next day and noted that Mr Evans was in good spirits.

53. A nurse tried to review Mr Evans on 14 June. It was difficult to engage with him as he kept changing topic and shouted at staff who passed by. He said he should not be in prison and then walked away from their meeting.

54. The psychiatrist met Mr Evans later that day. She noted he was irritable and argumentative. He spoke about feeling paranoid, thought his vape had been spiked and said prisoners and prison officers were deliberately distressing him, including prisoners standing outside his cell door meowing. She noted she could not rule out the possibility that Mr Evans had a major mood disorder and currently presented as hypomanic. She recorded that mental health staff should continue to monitor Mr Evans, he should remain on diazepam, and she would review him again at her next clinic.

55. An OM held a case review on 23 June, attended by Mr Evans, a nurse and an officer. He noted that Mr Evans seemed much better, could hold a conversation and appeared settled. Mr Evans said he had no thoughts of suicide or self-harm and was looking to the future. He said his solicitor was going to lodge another bail application and although he did not think it would be successful, he was happy it was being lodged. Staff reduced ACCT observations to one an hour.

56. The psychiatrist reviewed Mr Evans the next day, 24 June. He engaged with her, and she noted an improvement. She reduced Mr Evans' diazepam and said he should remain in SCU while being monitored on reduced medication.

57. On 30 June, an OM, a nurse and a peer prisoner supporter attended Mr Evans' ACCT review. They spoke in Welsh, which Mr Evans preferred. Mr Evans said he would like to return to X Block, but they told him that the psychiatrist had requested he stay on the SCU until he had been reassessed after his medication reduction.

58. After the case review, the nurse spoke to Mr Evans about the psychiatrist's recent diagnosis of hypomania. Mr Evans was upset and said the psychiatrist was incorrect and thought it would negatively impact his court case. The nurse spoke to the psychiatrist on 4 July. They agreed he would stop taking diazepam and be monitored before he returned to X Block.

X Block – 6 July to 11 August

59. Mr Evans returned to X Block on 6 July. An OM held a case review with Mr Evans the next day. She noted he was looking to the future and had no thoughts of suicide or self-harm. She stopped ACCT observations, and reduced conversations to two a day.

60. The psychiatrist reviewed Mr Evans on 8 July. She noted that his manic episode was resolving, no further concerns had been raised about his behaviour, and he no longer took diazepam. She planned to see Mr Evans again in a month, or sooner if his presentation deteriorated again.

61. Mr Evans telephoned the Prison Reform Trust's information line on 14 July. He requested information about disclosure of evidence in criminal cases which arrived at the prison after he had died.

62. An OM held a case review on 15 July, attended by Mr Evans and a nurse. They agreed that Mr Evans' risk of self-harm had reduced, and the ACCT should be closed. Mr Evans had engaged well, spoke about teaching Welsh, and wanted to work in the print workshop. The OM noted that Mr Evans had been doing well on X Block since returning from the SCU.

63. Mr Evans was scheduled to see the optician on 19 July, but the optician did not have time. Mr Evans was put on a non-urgent list, but as a high priority.

64. An OM held an ACCT post-closure interview with Mr Evans on 22 July. Mr Evans said he was feeling well and had settled into prison life, was sleeping, had contact with his family and raised no concerns. The OM concluded that the ACCT should remain closed.

65. The psychiatrist saw Mr Evans on 5 August. She noted that Mr Evans was engaging with the prison regime, working and going to the gym. He said he was sleeping and eating well. Mr Evans said he had had some difficult meetings with his solicitor but said his mood was okay. Mr Evans attributed his previous behaviour when he was in SCU to a period of adjustment, as it was his first time in prison. Mr Evans said he had not experienced any difficulties on his return to X Block. Mr Evans' main concern was seeing the optician as he needed new glasses. She

discharged Mr Evans from the mental health team's caseload, but said he was to be re-referred if he experienced any issues. She also noted she would chase up his optician's appointment.

66. Mr Evans met with his solicitor on 11 August. The investigator contacted the solicitor to ask if they would share details of their discussion with Mr Evans, but they did not respond.

Events of 12 August 2022

67. At 7.00am on 12 August, Officer A carried out a roll check. He arrived at Mr Evans' cell at 7.05am. He remembered Mr Evans put his thumbs up to indicate he was okay. At 7.23am, Officer B left Mr Evans' breakfast pack outside his cell, and a minute later delivered some milk. At 7.31am, Officer A unlocked Mr Evans' door and gave him his breakfast. At 8.03am, Officer C unlocked Mr Evans' door so he could go to work in the print workshop. At 8.35am, Officer B looked into Mr Evans' cell and saw him sitting on the bed watching television. Mr Evans said "alright", then he relocked the door.

68. A short time later, a member of staff from the print workshop telephoned X Block and asked where Mr Evans was. Officer C said she would check but then got caught up with other tasks. The print workshop telephoned again just before 9.55am. Officer A said he would speak to Mr Evans.

69. Officer A arrived at Mr Evans' cell at 9.56am. He looked through the observation panel and saw Mr Evans lying on the floor with his head under a chair. He could see Mr Evans was suspended by a ligature, made from a plastic washing loofah and thin lace, tied to the chair. He immediately radioed an emergency code blue (indicating a person is unconscious or not breathing) and also shouted for staff to help him. He then pushed his way into the cell as Mr Evans had barricaded it. Officer A and Officer C removed the ligature from around Mr Evans' neck and checked for signs of life. They found none so started cardiopulmonary resuscitation (CPR). They attached a defibrillator which advised no shock. The officers then saw Mr Evans had also cut his wrists.

70. Two nurses and other healthcare staff responded to the code blue call. Staff were already performing CPR. One nurse assessed Mr Evans and performed one round of chest compressions before ambulance paramedics took over. They continued CPR but, at 10.52am, pronounced that Mr Evans had died.

Contact with Mr Evans' family

71. A prison manager was appointed as family liaison officer. She and the Deputy Director visited Mr Evans' next of kin to break the news of his death.

72. The prison contributed to the cost of Mr Evans' funeral in line with national instructions.

Support for prisoners and staff

73. After Mr Evans' 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.

74. The prison posted notices informing other prisoners of Mr Evans' 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 Evans' death.

Post-mortem report

75. Mr Evans' post-mortem concluded he died from hanging. His toxicology test showed no sign of drug use.

Findings

Management of Mr Evans' risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk from self, from others and to others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify a prisoner at risk of suicide and self-harm.

77. Staff started ACCT monitoring for Mr Evans when he arrived at Parc on 8 April, and it continued until 15 July. We found that staff made considerable efforts to engage meaningfully with him, although this was sometimes difficult. Mr Evans' ACCT documentation, including the care plan and on-going record, was completed well. We consider that the decisions to close the ACCT on 15 July, and to keep it closed at the post-closure review a week later, were both reasonable in the circumstances. There was no indication that Mr Evans was at imminent risk of suicide at that time.

78. However, we have concerns about some aspects of ACCT management. PSI 64/2011 says that the ACCT case coordinator should ensure that healthcare staff are always invited to attend, or provide a written contribution to, all case reviews where they are relevant to supporting the prisoner. As Mr Evans clearly had mental health issues, was referred for a mental health assessment and was subsequently supported by the mental health team, we are concerned that no one from that team, or any member of healthcare staff, was invited to the case reviews held on 13 April, 19 April, 25 April, 9 May, 11 May, 13 June and 7 July. PSI 64/2011 also says that other staff relevant to supporting the prisoner should be invited to, and attend, case reviews. It lists suggested staff members, including the prisoner's keyworker. Mr Evans had regular key worker sessions, but his key worker was present at only one case review. We note that some ACCT case review meetings were held with only one member of staff present which is poor practice.

79. We note that Mr Evans' family was listed as a source of support in the ACCT document. There is no evidence that the ACCT case coordinator tried to engage Mr Evans' family in the ACCT process.

80. We recommend:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with policy, and in particular, staff should:

- **ensure relevant staff involved in the prisoner's care, including healthcare staff where appropriate, are invited to all case reviews and**
- **involve a prisoner's next-of-kin in the ACCT process when appropriate.**

Clinical care

Mental health

81. The clinical reviewer considered that there was a long delay before Mr Evans had a mental health assessment. Mr Evans was referred to the mental health team on 9

April but was not seen by a mental health nurse until 7 May. The clinical reviewer noted that most urgent referrals should be seen within five days in the community. It appears that the original referral was missed as an entry in the medical record refers only to a referral made on 2 May. We recommend:

The Head of Healthcare should ensure there is an effective system for urgent mental health referrals to be tracked and carried out within a reasonable timescale.

82. The clinical reviewer noted that Mr Evans lost 12kg in weight (15% of his body weight) in ten weeks, which indicated severe malnutrition was occurring. The clinical reviewer thought that this significant weight loss should have been referred to an appropriate member of healthcare staff, and the prisoner monitored and assessed for possible causes. The clinical reviewer noted that the weight loss stabilised and then improved once the psychiatric crisis had passed. He considered it likely that Mr Evans had not eaten enough due to a severe mental illness and that if he had been given antipsychotic mediation earlier, it is possible he might have made a quicker recovery. We recommend:

The Director and Head of Healthcare should ensure that if staff notice that a prisoner has lost a significant amount of weight, they refer them to a medical professional who can assess them for possible causes.

83. The clinical reviewer was concerned that given Mr Evans' considerable weight loss, history of bizarre behaviour and the fact he was living in a room contaminated with excrement, he did not receive adequate assessment and treatment for an apparent serious mental illness (subsequently diagnosed as bipolar affective disorder). The clinical reviewer said that when Mr Evans' presentation was most disturbed, it would have been appropriate to assess whether he should be detained under the Mental Health Act and moved to a psychiatric facility, but there is no evidence that healthcare staff considered this. We recommend:

The Head of Healthcare should ensure that prisoners who appear acutely, psychiatrically unwell are considered for transfer to a psychiatric hospital, and these discussions are recorded in the medical record.

Lack of access to contact lenses/glasses

84. Mr Evans was severely short sighted and wore glasses or contact lenses. Mr Evans asked for his glasses, which were subsequently posted into him, but he did have several weeks when it appeared he had no access to either contact lenses or glasses so his vision would have been impacted. He also asked for an optician appointment to have an eye test but was never seen while at Parc.

85. We do not think that this severely impacted on Mr Evans' ability to integrate into prison life as he was able to work in the print shop, however, Parc's Service Level Agreement (SLA) with the optician says that routine appointments should be seen within six weeks of application or referral. The optician did not see Mr Evans within their prescribed timeline.

86. We recommend:

The Director and Head of Healthcare should ensure that:

- **corrective visual aids are made available as a priority to prisoners who need them for daily living activities; and**
- **prisoners are seen by the optician within the timelines set out in their Service Level Agreement.**

Inquest

87. The inquest, held on 30 January 2025, concluded that Mr Evans died by ligaturing himself in circumstances where his intention could not be ascertained.

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