Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Evans, on 22 May 2024, following his release from HMP Stoke Heath

A report by the Prisons and Probation Ombudsman

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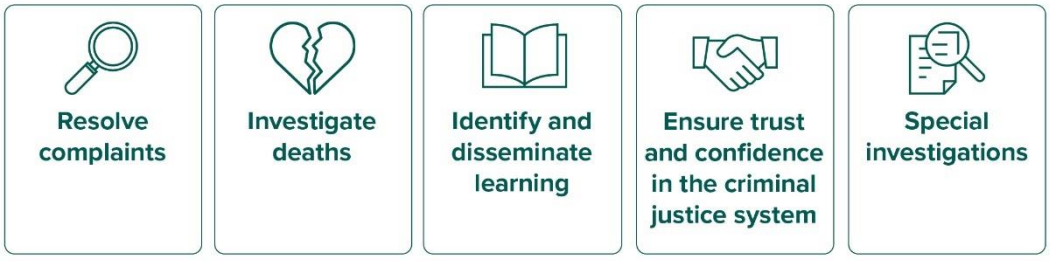
OUR VISION

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

Summary

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Daniel Evans died of acute kidney injury (non-traumatic), caused by an upper gastrointestinal haemorrhage, on 22 May 2024 following his release from HMP Stoke Heath on 16 May 2024. He was 39 years old. I offer my condolences to those who knew him.

5. When Mr Evans' community offender manager (COM) was on sick leave, his case was not reallocated, which meant that referrals to arrange accommodation for him were not completed and he was released homeless. However, given the staffing pressures across the Probation Service and the recent policy change on timescales for reallocating cases, we do not make a recommendation about this.

6. The clinical reviewer concluded that the clinical care Mr Evans received at Stoke Heath was not of a good standard and was not equivalent to that which he could have expected to receive in the community. She found that Mr Evans had a diagnosed health condition which was not clearly documented or adequately monitored. However, she concluded that this was not relevant to the cause of Mr Evans' death.

7. The clinical reviewer made four recommendations which were not related to Mr Evans' death but which the Head of Healthcare at Stoke Heath will want to address.

The Investigation Process

8. Staffordshire and Stoke-on-Trent Coroner's Service notified us of Mr Evans' death on 3 June 2024. We have sent the Coroner a copy of this report.

9. The PPO investigator obtained copies of relevant extracts from Mr Evans' prison and probation records.

10. NHS England commissioned a clinical reviewer to review Mr Evans' clinical care at HMP Stoke Heath.

11. The investigator interviewed a Senior Probation Officer on 18 July 2024. She and the clinical reviewer also interviewed four members of healthcare staff at Stoke Heath on 12 and 13 August 2024.

12. The Ombudsman's office contacted Mr Evans next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Stoke Heath

14. HMP Stoke Heath is a category C training and resettlement prison and young offenders' institution which holds convicted male prisoners. The healthcare provider is Shropshire Community Health NHS Trust.

Probation Service

15. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to which, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

16. In April 2022, Mr Daniel Evans was convicted of drug offences and was sentenced to two years and three months in prison. He was released on licence in November 2022 but was recalled to prison on 21 March 2023. He was released again on 3 April.

17. On 22 July, Mr Evans was recalled to HMP Altcourse, charged with possessing an offensive weapon.

Pre-release planning

18. On 3 August 2023, Mr Evans was transferred to HMP Stoke Heath and attended an initial health screen with a nurse. Mr Evans reported a history of drug misuse, so she referred him to the substance misuse team who then saw him regularly.

19. On 8 August, Mr Evans' Prison Offender Manager (POM) emailed Mr Evans' Community Offender Manager (COM) to introduce herself.

20. On 11 August, the COM completed an assessment of Mr Evans' risks and needs in the community in preparation for his release. A Senior Probation Officer (SPO) told us that a further assessment should be completed within 15 days of release, but Mr Evans died before then.

21. On 14 August 2023, Mr Evans was sentenced to six months in prison for possessing an offensive weapon.

22. On 18 August, the POM met Mr Evans for an initial interview. She remained in regular digital communication with him throughout his time at Stoke Heath.

23. On 4 April, the COM went on long-term sick leave. She told us that she had planned to complete accommodation referrals for Mr Evans before she went on sick leave but had not managed to do so due to her large caseload. The SPO told us that due to staffing pressures, Mr Evans' case was not reallocated in his COM's absence and, therefore, accommodation referrals were not completed in preparation for Mr Evans' release.

24. On 23 April, Mr Evans did not attend an appointment with the pre-release clinic, where he would have been supported to register with a GP practice.

25. On 25 April, a GP operating at Stoke Heath prescribed Mr Evans a month's supply of medication to ensure he had enough until he had registered with a community GP.

26. On 7 May, the POM emailed the healthcare team, informing them of Mr Evans' upcoming release date. A nurse referred Mr Evans to the community drug and alcohol service.

Release from HMP Stoke Heath

27. On 16 May, Mr Evans was released from Stoke Heath. He attended an induction with a Probation Officer. He told her he was homeless. She asked if he wanted her to contact the council, but he told her that it was 'pointless' and 'a waste of time'. A SPO told us that they were unable to complete a referral to the local authority for accommodation because Mr Evans' consent was needed. Mr Evans' next appointment was arranged for 23 May. (We do not know where Mr Evans lived on release.)

28. On 19 May, Mr Evans went to A&E by ambulance after he had chest pain and vomiting. The hospital treated him for a lower respiratory tract infection and discharged him with a prescription.

29. On 21 May, Mr Evans returned to A&E and told hospital staff about his history of abdominal pain, vomiting and black stools. He declined further assessment, including a blood test, and discharged himself from hospital. He was deemed to have mental capacity to make this decision.

Circumstances of Mr Evans' death

30. On 22 May, Mr Evans went to A&E by ambulance for abdominal pain, vomiting and black stools. He was referred to the acute medical team with a probable diagnosis of upper gastrointestinal bleed. He was moved to the intensive care unit, where he continued to deteriorate.

31. At 9.57pm that day, Mr Evans had a cardiac arrest and died.

32. On 23 May, the community substance misuse service phoned the Probation Service to tell them that Mr Evans had died in hospital the previous day.

Post-mortem report

33. A hospital doctor established that Mr Evans died from acute kidney injury (non-traumatic), caused by upper gastrointestinal haemorrhage. A post-mortem examination was not carried out as the Coroner accepted the cause of death.

Inquest

34. At an inquest held on 3 June 2025, the Coroner concluded that Mr Evans died of natural causes.

Findings

Clinical Findings

35. The clinical reviewer concluded that the care Mr Evans received at Stoke Heath before his release was not of a good standard and was not equivalent to that which he could have expected to receive in the community. She found that Mr Evans had a health condition (not related to the cause of his death) which was not clearly documented or adequately monitored. The clinical reviewer made four recommendations which were not related to Mr Evans' death, but which the Head of Healthcare at Stoke Heath will want to address.

Case reallocation in COM's absence

36. Mr Evans' COM went on long-term sick leave on 4 April 2024 and Mr Evans' case was not reallocated in her absence. This meant that accommodation referrals were not completed for him, and Mr Evans was released homeless.

37. The SPO told us that at this time, the Probation Office was experiencing extreme staffing issues and was operating as an Amber site (which meant that staff workload was at over 110% across Staffordshire), and therefore high-risk cases were prioritised. She told us that this meant it was not possible to reallocate all cases and Mr Evans was not categorised as posing a high risk. She told us that the usual practice was for cases to be reallocated when an officer had been off work for more than six weeks. Mr Evans was released exactly six weeks after Ms Shaw went on sick leave.

38. Since this time, changes have been made to the national Tiering and Case Allocation Framework to introduce new timescales for the reallocation of cases when a COM is absent from work. The policy states that if a COM is off work for four weeks, the case should be reallocated. The SPO told us she learned of this policy change on 19 July 2024.

39. Mr Evans' POM told us that it was the COM's responsibility to complete housing referrals, and she was not made aware that the COM was on sick leave from work. She also told us that since 1 July 2024, Stoke Heath's pre-release team can now also make accommodation referrals.

40. Although we recognise that Mr Evans died of natural causes, homelessness on release from prison remains a significant challenge for HMPPS and partner organisations in the community. Staffing pressures in the Probation Service are widely recognised and there are no short-term fixes, although HMPPS has introduced a number of actions to drive recruitment and improve the retention of trained staff. In light of this, and due to the recent policy change, we make no recommendation. However we note the impact overstretched services have on HMPPS's ability to prepare prisoners for release.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

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