Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dewi Evans a prisoner at HMP Gartree on 30 May 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Dewi Evans died on 30 May 2016 of pulmonary heart disease and chronic obstructive pulmonary disease at HMP Gartree. He was 66 years old. I offer my condolences to Mr Evans' family and friends.

The clinical reviewer found that Mr Evans' medical care in prison was of a standard equivalent to that which he would have received in the community. Healthcare staff created care plans, managed his chronic conditions well and prescribed appropriate medication. However, the clinical reviewer identified some learning points for healthcare in the prison. It is also disappointing that the news of Mr Evans' death was not broken to his daughter in person.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. Mr Dewi Evans was sentenced to life imprisonment on 26 July 2011. He was moved to HMP Gartree on 27 October 2013.

2. Mr Evans had a history of chronic obstructive pulmonary disease (COPD – lung disease), and coronary heart disease. He was a long term smoker and frequently declined help to stop. Nurses managed his conditions in line with his care plans.

3. Mr Evans saw a hospital respiratory specialist to monitor his condition and spent time in hospital when his COPD deteriorated. Prison GPs arranged for him to receive oxygen therapy in his cell.

4. At 7.41am on 30 May, Mr Evans complained of feeling unwell and a prison officer radioed an emergency medical code. A nurse assessed his symptoms and concluded he did not require hospital admission. At 11.05am, a prison officer found Mr Evans collapsed on his cell floor and radioed an emergency medical code. An ambulance was called; additional staff arrived within a few minutes and began cardiopulmonary resuscitation (CPR). The ambulance arrived at 11.25am and paramedics took over Mr Evans' care. Mr Evans continued to deteriorate and he died in hospital at 12.30pm.

Findings

5. The clinical reviewer found that Mr Evans' medical care in prison was of a standard equivalent to that which he would have received in the community. Healthcare staff created care plans, managed his chronic conditions well and prescribed appropriate medication.

6. However, the clinical reviewer identified some learning points for healthcare in the prison. In particular, we are concerned that the symptoms Mr Evans' displayed at 7.41am on 30 May were not fully assessed by medical staff. Staff did not take his temperature or measure his oxygen saturation level. The emergency response bag did not contain a pulse oximeter (used to monitor oxygen saturation levels), which would have provided valuable information. Closer assessment and monitoring of his deteriorating condition might have led to hospital intervention before his collapse less than four hours later.

7. We are also concerned that a prison family liaison officer did not break the news of Mr Evans' death to his daughter.

Recommendations

- The Head of Healthcare should ensure that staff check emergency response equipment regularly and after each use, and they record these checks.

- The Head of Healthcare should ensure that staff understand and use the MEWS tool to assess, monitor and respond to acute illness.

- The Governor should ensure that in the event of a death, the prisoner's next of kin is informed quickly and in person by a member of Prison Service staff in line with national guidance.

The Investigation Process

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

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

10. NHS England commissioned a clinical reviewer to review Mr Evans' clinical care at the prison. Our investigation was suspended until the clinical review report was received. We are sorry for the consequent delay in issuing this report.

11. We informed HM Coroner for Leicester City and South District of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Evans' daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no issues.

13. Mr Evans' daughter received a copy of the initial report. She did not make any comments.

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

Background Information

HMP Gartree

15. HMP Gartree, which is situated near Market Harborough in Leicestershire, holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Gartree was in March 2014. Inspectors were positive about the range and standard of health services. Prisoners' access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily with open access for prisoners with urgent needs. Prisoners were able to see a GP routinely within three days.

Independent Monitoring Board

17. 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 November 2015, the IMB reported that a delay in renewing the healthcare contract had caused some uncertainty but it had been decided that the existing providers would continue until 2017. The IMB was concerned that the growing number of older prisoners and those suffering from terminal illness or in need of operations would create a major problem in providing staff for escorts. Leicestershire County Council was working closely with the healthcare provider and the prison to help meet the social care needs of a number of older prisoners.

Previous deaths at HMP Gartree

18. Mr Evans was the fourth prisoner to die of natural causes at HMP Gartree since November 2014. We have made a recommendation about the use of the MEWS assessment tool before.

Key Events

19. On 20 November 2010, Mr Dewi Evans was remanded into custody at HMP Swansea charged with murder. On 26 July 2011, he was sentenced to life in prison. Mr Evans spent time in HMP Cardiff before moving to HMP Gartree on 27 October 2013.

20. Mr Evans had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema) and coronary heart disease. He had smoked for over 50 years and had declined help to stop. Prison GPs prescribed an inhaler and oral steroids to ease Mr Evans' COPD symptoms. Mr Evans suffered from depression and prison GPs prescribed anti-depressants to manage his symptoms. Prison GPs referred Mr Evans to the mental health team who assessed him regularly.

21. On 26 November 2013 at HMP Gartree, a prison GP arranged a full set of blood tests. On 28 November, the blood test results showed Mr Evans had an abnormal level of potassium. On 2 December, the GP repeated the blood test. He reviewed the results on 9 December and diagnosed Mr Evans with polycythaemia (a high concentration of red blood cells which makes the blood thicker and less able to travel through blood vessels and organs). The GP made a referral to the haematology team at the hospital.

22. On 7 April 2014, a consultant haematologist saw Mr Evans and diagnosed secondary polycythaemia caused by severe COPD. The consultant arranged a referral to the respiratory clinic at another hospital. On 22 April, a prison GP discussed Mr Evans' diagnosis with him.

23. On 2 June, a respiratory consultant saw Mr Evans and diagnosed advanced COPD respiratory failure. The consultant said if Mr Evans' condition continued to deteriorate he would benefit from long term oxygen therapy, but he would need to stop smoking.

24. On 7 July, Mr Evans told a prison GP he had cut down on cigarettes but he refused help to stop. She explained it was important for Mr Evans to stop smoking completely before he needed long term oxygen therapy.

25. On 15 August, Mr Evans attended the smoking cessation clinic and prison nurses gave him nicotine replacement patches. A few weeks later, Mr Evans told a smoking cessation nurse he had started smoking again.

26. On 10 November, prison nurses created a COPD care plan to monitor Mr Evans' lung function and a coronary heart disease care plan to ensure that nurses quickly noted any deterioration in his condition.

27. On 26 November, nurses recorded Mr Evans' oxygen saturation level at 80% (low). A prison GP decided that Mr Evans would benefit from oxygen therapy and made a referral to the home oxygen service at the hospital.

28. On 19 January 2015, Mr Evans did not attend an appointment for an oxygen therapy assessment at the hospital because he was unwell. His oxygen saturation level was low (79%) and a prison nurse gave Mr Evans oxygen (5

litres per min) which maintained his saturation level at 96%. On 29 January, a community nurse specialist visited Mr Evans in Gartree to assess his suitability for oxygen therapy. Mr Evans said he understood the risks of having oxygen therapy if he continued to smoke and agreed to attend the smoking cessation clinic.

29. On 11 March, a prison nurse recorded Mr Evans oxygen saturation level at 73% (low). The nurse took his clinical observations and applied a modified early warning system score (MEWS - a clinical assessment based scoring system aimed at the early identification of deteriorating patients) of three (a score of one to two would indicate a low cause for concern). The nurse gave Mr Evans oxygen (5 litres per min) which maintained his saturation level at 95%. Mr Evans said he had chest pains and the nurse performed an electrocardiogram (ECG) to check his heart rhythm. The results of the ECG were abnormal and the nurse arranged for an emergency ambulance to take Mr Evans to hospital. Two officers accompanied him and did not use restraints.

30. Hospital doctors diagnosed an exacerbation of COPD and treated Mr Evans with oxygen therapy. On 23 March, Mr Evans returned to Gartree. Prison GPs arranged for Mr Evans to receive oxygen therapy in his cell using a portable cylinder and a nasal cannula. Nurses created an oxygen therapy care plan to encourage independent and safe use of his oxygen therapy.

31. Nurses reviewed Mr Evans daily in accordance with his care plans. He continued to receive oxygen at five litres per min over a 24 hour period. On 7 August, a prison GP reviewed Mr Evans because his condition had deteriorated. The GP took his clinical observations and applied a MEWS score of three. Mr Evans' oxygen saturation level was 73%. The GP increased Mr Evans' oxygen to 6-10 litres per min, which maintained his saturation level at 88-92%. He arranged an emergency ambulance to take Mr Evans to hospital. Hospital doctors diagnosed an exacerbation of COPD and prescribed oral steroids. Mr Evans returned to Gartree on 8 August.

32. On 13 October, a nurse saw Mr Evans in his cell after he refused to use his oxygen. Mr Evans said he had difficulties with another prisoner and a prison officer. The nurse arranged a mental health review, which concluded that Mr Evans was frustrated by the limitations of his physical health. Mr Evans agreed to continue to use his oxygen therapy. Nurses created a mental health care plan to monitor his mood.

33. On 30 November, Mr Evans saw the respiratory consultant at hospital. The consultant said Mr Evans' condition had deteriorated and his life expectancy was less than five years.

34. Nurses continued to see Mr Evans on a daily basis to ensure that he was using his oxygen therapy in accordance with his care plan. Mr Evans complained of feeling increasingly breathless and intermittent chest pain. Nurses advised him to continue using his oxygen therapy.

35. On 31 March 2016, a respiratory consultant assessed Mr Evans and noted that his COPD had deteriorated. The respiratory consultant advised Mr Evans to use his oxygen therapy daily.

36. On 5 May, Mr Evans complained of chest pain and felling dizzy. Nurses immediately called an ambulance. The paramedics noted that Mr Evans' oxygen saturation level was 94% and his heart rate and blood pressure were within normal ranges. Mr Evans' respiratory rate was low. Paramedics gave Mr Evans medication to open his airways. Mr Evans said his chest pain had stopped and the paramedics decided not to take him to hospital.

37. On 9 May, Mr Evans complained of chest pain again and nurses called an ambulance. The paramedics took Mr Evans to hospital for further assessment. Hospital doctors prescribed antibiotics for a chest infection and increased Mr Evans' oxygen therapy to 6 litres per minute. Mr Evans' returned to Gartree on 10 May and nurses amended his oxygen therapy care plan.

30 May

38. At 7.41am on 30 May, a prison officer radioed an emergency code blue (which indicates a prisoner has symptoms including chest pain and difficulty in breathing) when Mr Evans complained of feeling unwell. The control room immediately called an ambulance. A nurse arrived a few minutes later and noted that Mr Evans appeared distressed and said he felt hot. She took his clinical observations but there is no record that she took Mr Evans' temperature, recorded his oxygen saturation level or applied a MEWS score. She encouraged Mr Evans to use his nebuliser and removed the sheets that were covering the air vents in his cell to cool it down. Mr Evans was alert and talking in full sentences and she concluded that he did not need hospital intervention. She told Mr Evans a nurse would see him again later that day, but did not record the intervals at which observations would take place.

39. At 11.05am, a prison officer found Mr Evans collapsed on his cell floor. He radioed an emergency code blue and the control room immediately called an emergency ambulance. A nurse arrived at 11.07am with the emergency bag. A few minutes later, two more nurses arrived with the defibrillator. Two nurses started cardiopulmonary resuscitation (CPR). The other nurse attached the defibrillator which did not detect a shockable rhythm.

40. At 11.25am, the ambulance arrived and took control of Mr Evans' care. Mr Evans left the prison at 11.35am for hospital. He was accompanied by a prison officer and a nurse, and was not restrained. Mr Evans continued to deteriorate and he died at 12.30pm on 30 May.

Contact with Mr Evans' family

41. At 1pm on 30 May 2016, the prison appointed a prison manager as family liaison officer. At 3pm, he telephoned Mr Evans' daughter and informed her of his death. He offered condolences and support.

42. The prison manager kept in contact with Mr Evans' daughter until his funeral on 16 June 2016. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

43. After Mr Evans death, the Deputy Governor 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.

44. The prison posted notices informing other prisoners of Mr Evans death and offered 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

45. The coroner concluded that the cause of death was cor pulmonale (pulmonary heart disease) and chronic obstructive pulmonary disease.

Findings

Clinical care

46. The clinical reviewer found that Mr Evans' medical care in prison was of a standard equivalent to that which he would have received in the community. Healthcare staff created care plans, managed his chronic conditions well and prescribed appropriate medication. However, the clinical reviewer identified some learning points for healthcare in the prison.

47. The clinical reviewer commented that, while healthcare staff used MEWS to assess Mr Evans, there were several instances when they did not record some elements of the assessment. When Mr Evans complained of feeling unwell at 7.41am 30 May, the nurse who assessed him did not record his temperature and his oxygen saturation level or apply a MEWS score. This would have provided healthcare staff with a more comprehensive assessment of his clinical condition and an indication of whether he required additional monitoring or hospital intervention. The consistent use of MEWS and more frequent monitoring might have provided a clearer picture of Mr Evans' condition prior to his collapse less than four hours later. We make the following recommendation:

    The Head of Healthcare should ensure that staff understand and use the MEWS tool to assess, monitor and respond to acute illness.

48. Mr Evans' medical record states the nurse who attended the first emergency response on 30 May was unable to record his oxygen saturation level because the emergency response bag did not contain a pulse oximeter (used to monitor oxygen saturation levels). This clinical observation was particularly important because Mr Evans suffered from advanced COPD. The nurse manager at Gartree told us that healthcare staff are required to check the emergency bags daily, usually in the morning. She was unable to confirm if healthcare staff had checked the bag taken to Mr Evans' cell on 30 May. We make the following recommendation:

    The Head of Healthcare should ensure that staff check emergency response equipment regularly and after each use, and they record these checks.

Family liaison

49. A prison manager acting as family liaison officer telephoned Mr Evans' daughter at 3pm on 30 May to inform her of his death.

50. PSI 64/2011 Safer Custody states "Wherever possible, the FLO (Family Liaison Officer) and another member of staff must visit in person the next of kin or nominated person to break the news of the death". Prison Service Order 1400 'Incident Management' states that the prison should try to deliver the news themselves or at the very least via prison staff from a prison local to the next of kin.

51. The family liaison officer told us that he decided to telephone Mr Evans' daughter because he did not have next of kin details recorded on his prison record. He

said that Mr Evans' prison record listed his daughter's telephone number but did not record her address.

52. The investigator obtained a copy of Mr Evans' prison record which recorded his daughter as his next of kin along with her home address. We do not consider it appropriate that the prison's FLO telephoned Mr Evans' daughter to break the news of his death. There was no justification for not informing her in person, particularly as Mr Evans' death was unexpected. We note that Mr Evans' daughter lived almost four hours away from the prison. In these circumstances, staff from the prison located nearest to the next of kin should have been asked to visit Mr Evans' daughter to break the news. We make the following recommendation:

The Governor should ensure that in the event of a death, the prisoner's next of kin is informed quickly and in person by a member of Prison Service staff in line with national guidance.

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