

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr William Bevan, a prisoner at HMP Littlehey, on 14 February 2021

**A report by the Prisons and Probation Ombudsman**

## 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*



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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr William Bevan, who was 59 years old, died of advanced Parkinson's disease and dementia on 14 February 2021, while a prisoner at HMP Littlehey. We offer our condolences to Mr Bevan's family and friends.
4. The clinical reviewer concluded that the care Mr Bevan received at HMP Littlehey was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.
5. However, he made three recommendations about training for Advanced Care Planning, the use of the Death in Custody Charter and record keeping. We repeat his recommendations below.
6. We did not find any non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should consider a programme of training for all healthcare staff to ensure that Advance Care Planning is offered to prisoners so that they are able to make an informed choice when making decisions about their future care.
- The Head of Healthcare should consider using the Death in Custody Charter at HMP Littlehey as prisoners approach the end of their lives.
- The Head of Healthcare should ensure that healthcare staff consistently record the NEWS2 score when carrying out observations on prisoners.

## Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Bevan's clinical care at HMP Littlehey.
8. The PPO investigator has investigated non-clinical issues, including Mr Bevan's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. One of the PPO's family liaison officers wrote to Mr Bevan's next of kin, his mother, to explain the investigation. She asked about the treatment Mr Bevan received at Littlehey for his Parkinson's disease and requested a copy of our report.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies in the clinical review which has been amended accordingly. The action plan has been annexed to this report.

### **Previous deaths at Littlehey**

11. Mr Bevan was the 24<sup>th</sup> prisoner to die at Littlehey since February 2019. Of the previous deaths, 22 were from natural causes and one was a self-inflicted death. There have been eight further deaths since Mr Bevan's death, all from natural causes.
12. There are no similarities between our findings in the investigation of Mr Bevan's death and the previous deaths.

## Key Events

13. On 24 October 2013, Mr William Bevan was remanded to HMP Parc charged with multiple sexual offences.
14. Mr Bevan did not have any pre-existing medical conditions. However, at his initial health screen at Parc, he told a prison nurse that he had depression. The nurse referred him to the prison's mental health in-reach team (MHIRT) for further review. However, Mr Bevan refused to engage.
15. On 5 November, a prison GP saw Mr Bevan. The GP noted there was a slowness to Mr Bevan's movements and responses to questions he was asked. The GP considered he may be experiencing symptoms of Parkinson's disease (a progressive nervous system disorder caused by the loss of cells in part of the brain). He asked Mr Bevan about his family history and Mr Bevan said he had aunts and uncles that had suffered from the condition. The GP made a referral to the hospital neurological team.
16. On 15 November, Mr Bevan was sentenced to 19 years imprisonment. He returned to HMP Parc.
17. In June 2014, the hospital saw Mr Bevan, but they found no evidence of Parkinson's disease.
18. In 2015, Mr Bevan transferred to HMP Rye Hill.
19. In June 2016, a prison nurse saw Mr Bevan after he tripped and fell while walking up a flight of stairs. He told the nurse that he had recently experienced bouts of unexplained dizziness two or three times a day. She referred him to a prison GP for review.
20. A prison GP saw Mr Bevan later the same day. She noted that he had a tremor in his right leg and signs of mild cognitive impairment. She adjusted his medication and planned to review him the following month. The GP saw Mr Bevan a month later as planned and noted an improvement in his condition. Mr Bevan was regularly reviewed by prison healthcare staff in the months that followed.
21. On 3 January 2018, Mr Bevan transferred to HMP Littlehey.
22. A nurse carried out an initial health screen. Mr Bevan told her that he had been reviewed for possible Parkinson's disease, but a formal diagnosis had not been made. The nurse referred him to a prison GP.
23. A prison GP saw Mr Bevan on 15 January. She noted that the possibility of Parkinson's disease had been considered at both Parc and Rye Hill but no formal diagnosis had been made. She also noted that adjustments to his prescribed medications had improved his condition. She referred Mr Bevan to the neurological team at Addenbrookes Hospital, Cambridge. She also made a referral to the MHIRT, but Mr Bevan refused to engage.
24. Mr Bevan attended hospital on 4 May and was diagnosed with Parkinson's disease. Mr Bevan was regularly reviewed by both prison healthcare staff and

secondary care staff. Care packages were created to manage his care and a social care package was put in place to assist him with daily tasks.

25. On 30 October, a prison GP saw Mr Bevan after he complained of some memory loss. The GP completed a General Practitioner Assessment of Cognition (GPCOG), a screening tool for dementia. Mr Bevan's score was 3, which indicated that he had cognitive impairment. The GP considered this was possibly secondary to Parkinson's disease.
26. On 7 October 2019, a palliative care consultant saw Mr Bevan. She conducted a cognitive impairment test and the results indicated that Mr Bevan had a moderate to severe level of dementia. She discussed Mr Bevan's wishes in respect of resuscitation, while he had the capacity to make an informed decision. He said that he did not wish to be resuscitated if his heart or breathing stopped and on 14 October, he signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect.
27. On 18 December 2020, a prison GP saw Mr Bevan. He noted Mr Bevan's condition had deteriorated and that he was extremely frail. He considered he was displaying signs of dyskinesia (involuntary erratic writhing movements of the face and arms, legs or trunk associated with Parkinson's disease). He requested a follow up review by another prison GP for a second opinion.
28. On 13 January 2021, another prison GP saw Mr Bevan for his follow up review. He noted that Mr Bevan was having difficulty swallowing both fluids and solids. He referred him to the Ear Nose and Throat team at Addenbrookes Hospital.
29. On 1 February, the palliative care consultant saw Mr Bevan again. She noted he was unresponsive to her questions and unable to swallow even small sips of water. She sent him to hospital by emergency ambulance. He was accompanied by two officers and he was not restrained. Mr Bevan was admitted to hospital as an inpatient for end of life care.
30. Mr Bevan's condition deteriorated further in hospital and on 5 February, he was moved to St John's Hospice, Bedford.
31. Mr Bevan's condition continued to deteriorate and at 2.50am on 14 February, it was confirmed that Mr Bevan had died.

#### **Cause of death**

32. The Coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave Mr Bevan's cause of death as advanced Parkinson's disease and dementia.

**Lisa Burrell**  
**Assistant Ombudsman**

**January 2022**