Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ellis Williams, a prisoner at HMP/YOI Parc, on 31 March 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 Ellis Williams, who was 79 years old, died of hospital acquired pneumonia on 31 March 2021 while a prisoner at HMP Parc. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the care that Mr Williams received at HMP Parc was equivalent to that which he could have expected to receive in the community.

5. He was, however, concerned that although Mr Williams received a good standard of ongoing care for his diabetes, a formalised care plan was not created to manage that care. He was also concerned that there was no evidence in Mr Williams' medical records to suggest he had been referred for diabetic eye screening or foot care.

6. The clinical reviewer found that although healthcare staff made a referral to the older people's mental health services due to concerns about Mr Williams' memory, the service was unable to accept the referral because they did not conduct assessments for prisoners. He was also concerned that healthcare staff made changes to Mr Williams' prescribed medications without informing him that they had done so. The clinical reviewer made three recommendations which we repeat below.

7. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that healthcare staff create care plans for diabetic prisoners so that all aspects of their care are effectively managed.

- The Head of Healthcare should ensure that there are formalised arrangements in place for the onward referral of prisoners to a local memory team.

- The Head of Healthcare should ensure that prisoners are fully informed about any changes made to their prescribed medications or any diagnoses made about their health.

Investigation Process

8. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Williams' clinical care at HMP Parc.

9. The PPO investigator has investigated non-clinical issues, including Mr Williams' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

10. The Ombudsman's family liaison officer wrote to Mr Williams' next of kin, his daughter to explain the investigation. She raised a number of concerns and asked about the following:

- the management of Mr Williams' diabetes at Parc;
- the timeliness of the diagnosis of any urine infections; and
- Mr Williams' weight loss at Parc

11. We have addressed the issues that are within our remit in this report and in the clinical review.

12. Mr William's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

13. 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.

Previous deaths at Parc

14. Mr Williams was the twenty second prisoner to die at Parc since March 2018. Of the previous deaths, thirteen were from natural causes, five were drug-related and three were self-inflicted. Since Mr Williams' death, there have been seven deaths, five from natural causes and two were drug related.

Key Events

2020

15. On 27 July 2020, Mr Ellis Williams was charged with sexual offences and sentenced to four years in prison. He was sent to HMP Parc. Mr Williams had several pre-existing medical conditions, including Type 2 diabetes, raised cholesterol, arthritis, angina, and he had previously had a mild stroke.

16. During his initial health screen, Mr Williams told the nurse that he had chest pains. She carried out an electrocardiogram (ECG), but the results showed nothing of note. She advised him to use his prescribed GTN spray and to tell staff if his condition did not improve.

17. The nurse was concerned that Mr Williams appeared vague and forgetful. She considered that he might be displaying signs of dementia and referred him to the prison's mental health inreach team for a cognitive assessment. She also referred him to the prison's specialist diabetic care clinic. Healthcare staff did not create a care plan to manage Mr Williams' diabetes as they should have done.

18. On 24 August, a prison GP saw Mr Williams after he complained of difficulty passing urine over the previous two weeks. She carried out a urine test to check for infection and a blood test to check his prostate antigen level (used as an indicator of possible prostate cancer). The urine test result did not show any evidence of infection. However, the test result showed a raised prostate antigen level of ten, a borderline reading which needed ongoing monitoring (a normal prostate antigen level is five or less).

19. On 2 September, a nurse from the prison's mental health inreach team carried out an orientation test. The results indicated that Mr Williams would benefit from a Montreal Cognitive Assessment (which assesses the level of cognitive impairment). The assessment took place on 19 October, and the result indicated that his cognitive ability was below the normal range. The mental health inreach team monitored him every six weeks.

20. On 3 September, a prison GP saw Mr Williams. He noted the results of the recent urine and prostate antigen level tests and considered Mr Williams would benefit from a rectal examination. He noted Mr Williams' prostate was enlarged but not painful. He planned to repeat the prostate antigen test in four weeks' time.

21. A few weeks later, another prison GP carried out the follow-up review. The GP noted that Mr Williams was still displaying symptoms of a urine infection, despite the test result showing nothing of note. The GP prescribed Mr Williams with a course of antibiotics and referred him to the urology department at the hospital for further review.

22. On 21 October, a nurse saw Mr Williams after he complained of feeling unwell. He told her that he had had diarrhoea since the previous day. She noted that he was unsteady on his feet. She took his blood sugar level, and the result was low. She sent him to hospital by emergency ambulance.

23. The hospital diagnosed Mr Williams with a kidney injury (a condition in which the kidneys do not function correctly). He was admitted to hospital as an inpatient and had a catheter inserted. He was discharged from hospital and returned to Parc on 29 October.

24. On 9 November, a prison GP saw Mr Williams. She noted that he had been discharged from hospital with a long-term catheter in place. She also noted that he had lost fifteen kilograms since his arrival at Parc. She recommended that healthcare staff complete weekly food and fluid intake charts to monitor his intake, and complete regular blood tests. Over the following weeks, Mr Williams' condition improved.

25. On 30 December, Mr Williams attended hospital for his planned urology appointment. When he returned to the prison, healthcare staff noted that he appeared confused and could not remember any details of his urology review. Healthcare staff referred him for an urgent GP review.

26. On 31 December, a prison GP saw Mr Williams. She noted his urology review had found a benign prostate hypertrophy (a benign condition in which an overgrowth of prostate tissue blocks the flow of urine). She was concerned that he appeared confused, disorientated and agitated, and that his condition had deteriorated rapidly. She sent him to hospital by emergency ambulance. Mr Williams was admitted as an inpatient and his prescribed medications were reviewed and adjusted.

2021

27. On 18 January 2021, Mr Williams was discharged from hospital and returned to Parc. Social carers were appointed to assist him with daily tasks and healthcare staff reviewed him regularly.

28. On 8 February, nursing staff repeated the Montreal Cognitive Assessment. Mr Williams struggled throughout the assessment, and his score indicated a severe level of impairment.

29. On 21 February, a nurse saw Mr Williams. She noted that his condition had deteriorated and that he was confused and disorientated. She asked another nurse to review him. They sent him to hospital for an urgent review and he was admitted as an inpatient.

30. Mr Williams' condition continued to deteriorate in hospital and, at 5.35pm on 31 March, Mr Williams died. At 5.45pm, a hospital doctor confirmed his death.

Cause of death

31. The coroner gave Mr Williams' cause of death as hospital acquired pneumonia caused by discitis (an infection of the intervertebral disc space). He also had ischaemic heart disease, Type 2 diabetes and dementia which did not cause but contributed to his death.

Inquest into Mr Williams' death

32. The inquest into Mr Williams' death was held on 24 May 2023 and a verdict of natural causes was recorded.

33. The coroner concluded Mr Williams' death was due to aspiration pneumonia, poor swallow caused by dementia and discitis (infection of the intervertebral disc space.)

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

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