Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leonard Evans a prisoner at HMP Altcourse on 8 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*

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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 Leonard Evans died on 8 May 2016 of lung cancer, while a prisoner at HMP Altcourse. He was 53 years old. I offer my condolences to Mr Evans family and friends.

While aspects of Mr Evans' healthcare at Altcourse were good, I am not satisfied that overall he received a standard of care at the prison equivalent to that he could have expected to receive in the community. I recognise that Mr Evans sometimes refused clinical investigations, but he also missed appointments because of poor prison administration and communication with the hospital. Moreover, healthcare staff did not implement palliative or end of life care plans for Mr Evans and recording required improvement - an issue I have raised previously with Altcourse.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2016**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Findings 5

Summary

Events

1. On 10 November 2015, Mr Leonard Evans was remanded to HMP Altcourse charged with wounding with intent.

2. Within two days of arriving at Altcourse, a prison GP saw Mr Evans who said he had been coughing up blood and had lost weight. The GP referred him to a specialist under the NHS pathway that requires patients suspected of having cancer to be seen by a specialist within two weeks. Mr Evans underwent a CT scan on 19 November. On 24 November, hospital doctors told him that the results showed a mass in the right of his chest. He initially refused further investigations, because of a fear of needles and certain procedures, and doctors found it difficult to get him to agree to any type of investigations.

3. On 30 December, Mr Evans was scheduled to have a another scan, but poor communication between healthcare staff and prison staff meant that Mr Evans was taken to the wrong hospital department so missed the appointment. There were other instances of missed appointments and poor record keeping by healthcare staff.

4. On 20 January 2016, Mr Evans was sentenced to six years in prison. The same day he went to hospital after coughing up blood, doctors diagnosed a chest infection and prescribed antibiotics. He returned to Altcourse the same day.

5. On 4 February, Mr Evans had a bronchoscopy and a specialist confirmed he had stage three to four cancer with lymph node involvement, but did not specify where the cancer was. There are four stages of cancer which indicate the size and spread of the tumour itself and the disease, with stage one being the smallest and most contained and stage four when it has spread to other parts of the body.

6. Healthcare staff suggested that Mr Evans move to the prison's inpatient unit. He declined initially but was eventually moved there in February. Mr Evans remained in the inpatient unit apart from two visits to a hospice for blood transfusions. He continued to be reluctant to undergo further investigation. Mr Evans was self-caring until the last few days of his life. Healthcare staff managed his pain, but there were no palliative or end of life plans in place.

7. Mr Evans deteriorated and was taken to hospital on 6 May. He remained very ill and died on 8 May, his family were with him.

Findings

8. We share the clinical reviewer's concern that important hospital appointments were missed because of poor communication between prison and healthcare staff. Healthcare record keeping was poor, with little or no information about important appointments and treatment. Although healthcare staff did their best to manage Mr Evans' pain, we are concerned that there was no palliative care or end of life plan in place.

Recommendations

- The Governor and the Head of Healthcare should ensure that prison and healthcare staff communicate effectively with each other and outside agencies to ensure that prisoners’ appointments are not missed.
- The Head of Healthcare should ensure that healthcare staff properly record all important information about prisoners’ care and appointments in line with Nursing and Midwifery Guidelines.
- The Head of Healthcare should ensure that an effective palliative care plan is implemented in a timely way for all prisoners who are terminally ill.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Altcourse 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. NHS England commissioned a clinical reviewer to review Mr Evans' clinical care at the prison.

12. We informed HM Coroner for Merseyside of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Evans' sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any matters for the investigation to consider.

14. The investigation has assessed the main issues involved in Mr Evans' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. Mr Evans' sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Altcourse

17. HMP Altcourse is a local prison in Liverpool, which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 sentenced and remanded adult and young adult men. G4S manage the prison and provide primary healthcare services. There is an inpatient unit with 12 beds and there is 24 hour healthcare cover.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Prisoners were generally positive about the care provided, especially in the inpatient unit. There were good arrangements for palliative and end of life procedures.

Independent Monitoring Board

19. 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 June 2015, the IMB reported that the 12 bed inpatient unit continued to manage and care for a diverse range of men. The healthcare management structure had been reformed and a new triage system had been introduced to reduce the length of waiting lists. Following the introduction of the Care Act 2014, the prison's links with the Local Authority had improved, although prison staff recognised that better links with Macmillan Nursing was required to enhance palliative care.

Previous deaths at HMP Altcourse

20. Mr Evans was the eighth prisoner to die of natural causes at Altcourse since May 2014. We have made recommendations about clinical record keeping before.

Findings

The diagnosis of Mr Evans' terminal illness and informing him of his condition

21. On 10 November 2015, Mr Leonard Evans was remanded to HMP Altcourse charged with wounding with intent. A nurse carried out a first night health screen and recorded that he had chronic obstructive pulmonary disorder (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and was on various medications for this. Mr Evans said he smoked 10 to 19 cigarettes a day but declined any assistance to give up. The nurse also noted that Mr Evans' body mass index was only 17, which meant that he was underweight, so she made an appointment for him to see a doctor.

22. On 12 November, a prison GP saw Mr Evans, who said he had been coughing up blood every day for a month and that he thought he had lost weight. Mr Evans refused to have blood tests as he was afraid of needles, despite the doctor explaining the importance of the tests. The doctor made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

23. Mr Evans had an X-ray on 16 November and a CT scan on 19 November. On 24 November, a lung specialist saw Mr Evans to discuss the scan results. He told Mr Evans that the scan had revealed a mass on the right hand side of his chest and an enlarged supra clavicular node (a lymph node near the collar bone). Initially Mr Evans said he would not have any further investigations involving needles and also refused a biopsy. However, he eventually agreed to blood tests and to provide a sputum sample. A further scan was arranged and for him to be reviewed in the lung clinic on 10 December.

24. On Mr Evans' return to the prison, a nurse spoke to him about the importance of providing samples and urged him to rethink his decision about the biopsy. Healthcare staff sent Mr Evans' sputum samples to the laboratory on 27 and 28 November.

25. On 22 December, Mr Evans attended a hospital appointment. A specialist wrote to the prison the same day saying that Mr Evans' presumed diagnosis was upper lobe lung cancer but that further investigations, including a PET/CT scan (a test that checks on changes in the activity of cells), were needed to confirm this. The specialist said that these tests should have taken place after the CT scan on 19 November but had not because of communication and logistical problems between the hospital's imaging service and Altcourse. He did not specify what the issues were but appeared to be referring to a clinic appointment on 10 December, which Mr Evans did not attend (it is not clear from the records why he did not attend).

26. The hospital scheduled a PET/CT scan for 30 December and the front page of the hospital appointment letter implied the appointment was in the PET/CT department so prison escorts took him there. The attached documentation explained that the appointment was in the hospital's Nuclear Medicine department and included a map and directions. However, finding that there was

no appointment scheduled for Mr Evans in the PET/CT department, the escorting officers returned with Mr Evans to the prison.

27. The hospital rescheduled the scan for 6 January 2016. Unfortunately, on 6 January, because of security issues, prisoners were not allowed to move around the prison, which meant that Mr Evans could not attend his appointment. The hospital rescheduled it again for 11 January and on this day Mr Evans had his scan.

28. On 20 January, Mr Evans appeared in court and was sentenced to six years in prison. He returned to the prison and, shortly afterwards, the escorting officers took him to Wrexham Royal Hospital because he had coughed up blood. Hospital doctors diagnosed a chest infection and prescribed antibiotics. Mr Evans returned to the prison the same day.

29. On 21 January, Mr Evans should have attended a bronchoscopy appointment. However, prison staff did not bring him to healthcare the night before to prepare for the procedure so the hospital rearranged it for 28 January. A lead nurse told us that Mr Evans refused to attend the rescheduled appointment. On the same day, Mr Evans was also due to have a hospital lung clinic appointment but the hospital cancelled and rescheduled it for 4 February.

30. On 30 January, a prison GP saw Mr Evans, who had been coughing up blood. The doctor noted hospital investigations were still ongoing and prescribed inhalers.

31. On 2 February, a prison manager asked a nurse to visit Mr Evans as staff were concerned he was not eating. The nurse attended and saw Mr Evans. He said that he often did not eat much but she was concerned enough to offer him admission to healthcare which he declined. He said his family knew about his condition and he did not want counselling. She made an appointment for him the next day to discuss taking nutritional drinks with a doctor but Mr Evans did not attend, it is not clear why not.

32. A hospital doctor saw Mr Evans on 4 February. He wrote to the prison's healthcare unit and explained that Mr Evans' biopsy result had not helped them confirm a diagnosis. The doctor explained that it had been difficult to do blood tests because of Mr Evans' needle phobia and that the next step was to do a biopsy on the supra clavicular node, which Mr Evans had agreed to.

33. On 12 February, Mr Evans was admitted to hospital because his blood pressure was 90/56 (low) and his oxygen saturation level was 86% (low). Hospital staff successfully took blood tests which indicated that he might have anaemia and clotting issues. Mr Evans discharged himself from hospital on 15 February. A doctor saw him and established that Mr Evans had had a blood transfusion in hospital, and taken some antibiotics so felt improved as a result. He would not agree to admission to the inpatient unit but said still wanted a lung biopsy.

34. On 16 February, Mr Evans was scheduled by the hospital to have a CT guided biopsy. He did not attend because the prison's system did not generate the appointment details (we were told this was because he had recently been in

hospital which overrides appointment reminders). The hospital rescheduled the appointment for 25 February.

35. On 18 February, nurses attended to Mr Evans in his cell as he was finding it difficult to breathe and admitted him to the inpatient unit overnight for monitoring. Mr Evans said he did not want to go to hospital and a prison GP saw him the next day and assessed him as stable. The GP spoke to Mr Evans about his wishes regarding resuscitation if his heart or breathing stopped, and Mr Evans said he would think about it when he had the results of further investigations.

36. On 29 February, a doctor wrote to Aintree University Hospital saying that Mr Evans might have had a recurrence of pneumonia, although he seemed quite well with minimal respiratory symptoms. He thought the pneumonia might be tumour related. The doctor wanted Mr Evans to have transfusion and a further biopsy. On the same day, Mr Evans declined to attend a hospital appointment as he did not feel well and signed a disclaimer to that effect.

37. On 1 March, the hospital admitted Mr Evans with suspected pneumonia. Hospital doctors gave him a nebuliser and at least one blood transfusion. The next day Mr Evans self discharged from hospital and signed a disclaimer regarding an appointment to discuss his options scheduled for 3 March. The hospital rescheduled the appointment for 24 March.

38. On 3 March, a respiratory specialist wrote to the prison following a multi disciplinary team meeting held that day. The team felt that unless Mr Evans agreed to another biopsy there was nothing more they could do for him, other than the provision of supportive care. He said that Mr Evans' frail state made him an unlikely candidate for chemotherapy and he wanted Mr Evans to talk through his options with someone at the hospital, which would happen at the appointment on 24 March.

39. Mr Evans remained on the prison's inpatient unit. A doctor spoke to him on 7 March and Mr Evans told him he had been unhappy with the conditions on the hospital ward so he had discharged himself. He said he only wanted to be admitted to hospital again if it was an absolute emergency.

40. On 10 March, a doctor noted that Mr Evans' wishes regarding resuscitation should be discussed, but Mr Evans said he needed to think about it.

41. On 11 March, Mr Evans told a doctor he would agree to a blood transfusion in a hospice setting. The next day a healthcare administrator contacted Woodlands Hospice to arrange the transfusion and they planned this for 28 and 29 March.

42. On 14 March, a doctor wrote to the lead nurse at the prison, explaining that Mr Evans probably had lung cancer but it had been difficult to confirm because he would not agree to some of the investigative procedures. His COPD and the problems caused by the probable tumour were making his breathing difficult. He explained that very little could be done for Mr Evans as he was too frail to withstand chemotherapy or radiotherapy. He also said that he had discussed the possibility of a blood transfusion with hospital consultants, which might help Mr Evans feel less tired and improve his breathing. He estimated Mr Evans'

prognosis at a few weeks to a few months but it was difficult to estimate. The doctor said he had discussed this with Mr Evans.

43. We are satisfied that the doctor appropriately referred Mr Evans for investigation when he originally saw him in November 2015 with concerning symptoms. However, after this, we consider there were a number of aspects of Mr Evans' clinical care which were not equivalent to that he could have expected to receive in the community.

44. Mr Evans did not attend an important clinic appointment on 10 December. It is unclear from the records why this was, although a hospital specialist gave the reason as communication issues between the hospital and prison. On 30 December, Mr Evans missed an appointment for a PET/CT scan because escorting officers were sent to the wrong hospital department, they did not make any enquires as to where he should be but returned to the prison.

45. On 20 January 2016, prison staff did not take Mr Evans to the healthcare department to prepare for a hospital appointment the next day, which would have included fasting and monitoring. A nurse told us that Mr Evans refused to go, but this was not recorded. We note that Mr Evans had been in court and hospital that day, and we consider it is more likely the arrangements became muddled as he had eaten a meal.

46. While we accept that Mr Evans sometime refused to attend appointments, it is unacceptable that he missed so many for other reasons. It is clear that there was poor communication between prison and healthcare staff and also the hospital around Mr Evans' appointments. Record keeping was generally poor both about Mr Evans' treatment and when appointments were due or whether they took place at all. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that prison and healthcare staff communicate effectively with each other and outside agencies to ensure prisoners' appointments are not missed.

The Head of Healthcare should ensure that healthcare staff properly record all important information about a prisoners' care and appointments in line with Nursing and Midwifery Guidelines.

Mr Evans' clinical care

47. On 15 March, Mr Evans and a nursing assistant completed a Preferred Priorities for Care document. (This document helps patients, families and carers understand what is important to the patient and assists with care planning accordingly). Mr Evans gave his sister's details as his next of kin and said he had yet to discuss his wishes about resuscitation with her. Mr Evans said he would prefer to die at her home or in a hospice closer to his sister. He said he understood his condition, and it was important to him that he was pain free and comfortable.

48. On 17 March, Mr Evans did not go to Woodlands Hospice for a blood transfusion as arranged, because he was not well enough. He said that he would agree to have one in hospital at another time.

49. On 20 March, a nurse noticed a medication error. Mr Evans was given 30mg instead of 10mg of morphine. A doctor advised healthcare staff to monitor Mr Evans every two hours, to perform neurological observations and not to give any further medication for the rest of the day. Records show he began to experience some pain as the dose wore off, but staff soon managed this.

50. On the same day, another nurse noted that Mr Evans had still not made a decision about resuscitation and in the event of his heart or breathing stopping, staff needed to attempt resuscitation.

51. On 21 March, altered Mr Evans' prescription for pain relief to 'as needed'.

52. On 24 March, Mr Evans was referred for radiotherapy and he also attended the lung clinic that day. The specialist wrote to the prison noting Mr Evans' decline and that they had discussed palliative radiotherapy.

53. On 29 March, Mr Evans went to Woodlands Hospice for a blood for transfusion. He returned to the prison later that day.

54. On 31 March, a doctor spoke to Mr Evans about his wishes with regard to resuscitation. Mr Evans said he would like to tell his sister what he decided himself, but that he did not wish anyone to resuscitate him if his heart or breathing stopped. The doctor formally recorded this decision.

55. Over the next two weeks, Mr Evans found it more difficult to keep his balance and swallow food and medication, but his pain was generally well controlled. However, there were some concerns that he did not always ask for medication unless prompted by staff.

56. Mr Evans had daily radiotherapy appointments at Clatterbridge Cancer Centre, Wirral from 12 April to 18 April and on 20 and 21 April. He missed two appointments because he did not feel well enough to attend.

57. Healthcare staff continued to care for Mr Evans by monitoring his fluid intake, encouraging him to have nutritional drinks, managing his pain relief and making sure he was generally comfortable. On 3 May, a healthcare assistant recorded that Mr Evans was still able to carry out most of his own personal care.

58. On 5 May, Mr Evans deteriorated significantly. He began to vomit in very large quantities, containing blood and suspected faecal matter. Healthcare staff called an emergency ambulance and the hospital admitted him. Mr Evans discharged himself, against medical advice, and returned to Altcourse in the early hours of 6 May. Staff persuaded him to return to the hospital, after he fell over and hurt his shoulder. Once back in hospital, Mr Evans did not want to cooperate with treatment. Hospital staff arranged for palliative care specialists to speak to him.

59. On 6 May, after initial resistance from Mr Evans, hospital staff fitted a syringe driver (which administers medication and pain relief continuously). They also gave him a blood transfusion. Mr Evans remained in hospital and continued to deteriorate. He died at 5.25am on 8 May.

60. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place to

help nurses plan a patient's care and help them make choices about how they are cared for towards the ends of their lives. We are satisfied that healthcare staff attempted to keep Mr Evans free from pain and that effective pain relief was readily available. Healthcare staff also made appropriate referrals to palliative care services, which allowed him to receive key clinical interventions, such as blood transfusions, while avoiding hospital admissions. However, we are concerned that none of this was carried out in a clearly planned way. Although a healthcare assistant discussed Mr Evans' wishes and opened a Preferred Priorities for Care document, a specific nurse was not allocated to Mr Evans to assist and support him. Also there was no palliative care plan or end of life plan, which would have ensured other relevant services were engaged (such as a dietician) and that Mr Evans' pain and symptomatic relief was delivered in a planned way. We make the following recommendation:

The Head of Healthcare should ensure that an effective palliative care plan is implemented in a timely way for all prisoners who are terminally ill.

Mr Evans' location

61. Mr Evans resided in single cell on a normal wing for most of the time he was in prison. He was very resistant to any attempt to admit him to the prison's inpatient unit, and healthcare staff saw him on the wing frequently. Eventually, Mr Evans moved to the healthcare unit on 18 February when healthcare staff wanted to observe him overnight, and he remained there until his final stay in hospital.

62. Until 3 May, Mr Evans was able to manage his personal care and we are satisfied that staff considered his wishes in allowing him to remain on the wing until his condition deteriorated.

Restraints, security and escorts

63. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

64. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

65. Mr Evans had a number of hospital appointments during his time at Altcourse. He had a number of high risk markers including violence. We are satisfied that medical input into the risk assessments for his hospital visits made clear that his condition did not impact on his risk of escape and there was no objection to restraints. Managers authorised officers to restrain him with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) which was removed for treatment.

66. As Mr Evans' condition deteriorated, we note that he was not restrained for appointments from 21 April. We are satisfied that there was appropriate

healthcare input into risk assessments for Mr Evans and managers were able to make proportionate decisions about the use of restraints.

Liaison with Mr Evans' family

67. On 20 February, the prison appointed an officer as the family liaison officer. Mr Evans told the family liaison officer that he spoke to his sister every day and she knew about his condition. With Mr Evans' agreement, the family liaison officer telephoned his sister on 7 March and met her when she visited Mr Evans at the prison on 9 March. The family liaison officer remained in contact with Mr Evans' sister.

68. On 5 May, the family liaison officer telephoned to let her know that Mr Evans had significantly deteriorated and was being admitted to hospital. Mr Evans' brother and sister were with him when he died on 8 May. After Mr Evans' death, the family liaison officer telephoned his sister to offer his support and condolences.

69. Mr Evans' funeral was on 26 May 2016. The prison contributed to funeral costs in line with national policy.

70. We are satisfied that there was good liaison and support for Mr Evans and his family. A family liaison officer was appointed early which ensured good communication and there was very good support for his family after his death.

Compassionate release

71. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

72. There is no record that the prison ever considered compassionate release for Mr Evans. However, Mr Evans repeatedly refused investigative procedures, so clinicians could not determine his exact diagnosis or likely prognosis. Without a clear prognosis any application was likely to have been unsuccessful. While we would expect to find a record of some discussion around compassionate release and the reasons for not making or progressing any application, in the circumstances we make no recommendation.

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