

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Evans, a prisoner at HMP Parc, on 5 February 2019

**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 Robert Evans died on 5 February 2019 of hospital acquired pneumonia, with a known history of liver and lung cancer and lung disease while a prisoner at HMP Parc. He was 66 years old. I offer my condolences to Mr Evans' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Evans received at Parc was equivalent to that which he could have expected to receive in the community. He made two recommendations about his clinical care.
5. We found no non-clinical issues of concern. We make no recommendations.

## Recommendations

- The Head of Healthcare should ensure that there is a system in place to identify and monitor blood tests that have been requested but not undertaken.
- The Head of Healthcare should ensure that the reception screening includes a recording of weight and that every time a weight recording is undertaken, it is documented clearly in the clinical record.

## The Investigation Process

6. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr Evans' clinical care at Parc.
7. The PPO investigator has investigated non-clinical issues, including Mr Evans' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Evans' next of kin, a friend, to explain the investigation. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at HMP Parc

10. Mr Evans was the 12<sup>th</sup> prisoner to die at Parc since December 2017. Of these deaths, seven were from natural causes and four were self-inflicted. There are no similarities between our findings in the investigation of Mr Evans' death and the other deaths.

## Key Events

11. Mr Robert Evans was serving time in prison for sexual offences and had been at HMP Parc since 3 August 2017.
12. When Mr Evans complained of abdominal pain, healthcare staff arranged for him to have a CT scan of his chest area and an ultrasound scan of his liver at a hospital. On 5 November 2018, prison staff sent him to hospital, unrestrained and escorted by two officers. The CT scan showed multiple abnormal growths in his lung and the ultrasound scan indicated that he had liver cancer which had spread.
13. On 3 December, Mr Evans slipped over in his cell and was confused. He refused to go to hospital and signed a disclaimer to that effect. The next day, as there was no improvement to his condition, Mr Evans agreed to go to hospital and was admitted as an inpatient. While in hospital, he developed a pressure ulcer.
14. On 14 December, staff started the process of applying for early release on compassionate grounds on Mr Evans' behalf. Mr Evans died before the application could be completed.
15. Mr Evans returned to Parc on 21 December. Healthcare staff created care plans to monitor his pressure ulcer and weight because he appeared to have difficulty eating.
16. On 25 January 2019, Mr Evans was confused and appeared dishevelled. Healthcare staff arranged for him to go to the hospital for review.
17. Mr Evans' condition continued to deteriorate and at 5.30am on 5 February 2019, it was confirmed that Mr Evans had died.

### Cause of death

18. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital doctor. The hospital doctor gave Mr Evans' cause of death as hospital acquired pneumonia caused by lung and liver metastatic cancer and COPD (chronic obstructive pulmonary disease).

**Sue McAllister**  
**Prisons and Probation Ombudsman**

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