

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Robinson a prisoner at HMP Littlehey on 2 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Philip Robinson died on 2 December 2016 of lung cancer while a prisoner at HMP Littlehey. He was 59 years old. I offer my condolences to Mr Robinson's family and friends.

I consider that Mr Robinson received a good standard of care at Littlehey. He was cared for in line with his wishes, and remained on a wing with his friends until he was transferred to a hospice, where he died. Although it did not affect the outcome for Mr Robinson, a chemotherapy care plan would have ensured an earlier diagnosis of a chest infection, which delayed radiotherapy treatment.

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

June 2017

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Summary

Events

1. Mr Philip Robinson was serving a nine year sentence and had been at HMP Littlehey since 4 September 2014. He had no significant health problems. Mr Robinson smoked heavily, and healthcare staff regularly advised him about smoking cessation, which he declined until he stopped smoking in September 2016.
2. On 11 April 2016, Mr Robinson saw a prison GP. He complained of suffering from a hoarse voice with occasional blood in his sputum. The GP referred Mr Robinson for an urgent chest x-ray and a review in two weeks, and prescribed an antibiotic.
3. There was an abnormality on the chest x-ray so a doctor arranged an urgent CT scan, blood tests and a chest review. On 28 April, a prison GP referred Mr Robinson under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
4. On 13 May, following medical investigations, a prison GP told Mr Robinson that he had suspected lung cancer, and referred him to a chest consultant. On 18 May, Mr Robinson saw a chest consultant at the hospital. They confirmed that there was a potential cancerous growth on Mr Robinson's lung.
5. From June to October, Mr Robinson received courses of chemotherapy and radiotherapy. One radiotherapy treatment in September was delayed because Mr Robinson had a chest infection. In November, his condition deteriorated and the cancer spread to his brain and pancreas.
6. On 26 November, Mr Robinson was admitted to hospital. His condition was terminal and, in line with his wishes, the prison transferred Mr Robinson to a hospice for palliative care on 29 November. He died on 2 December.

Findings

7. The clinical reviewer considered that the care Mr Robinson received was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Robinson received a good standard of care at Littlehey.
8. The clinical reviewer noted there was no daily record of Mr Robinson's temperature being taken while undergoing his chemotherapy. Temperature observations alert staff to any infections that may cause delays to treatment. Although it did not affect the outcome for Mr Robinson, his treatment was delayed for this reason on at least one occasion.

Recommendation

- The Head of Healthcare should ensure all prisoners undergoing chemotherapy have a care plan to reflect the specific needs of the individual.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Littlehey 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 Robinson's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison.
12. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation who informed us of Mr Robinson's cause of death. We have sent the coroner a copy of this report.
13. The investigator wrote to Mr Robinson's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. The investigation has assessed the main issues involved in Mr Robinson's 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. The initial report was shared with the Prison Service. They have not detailed any factual inaccuracies. We are disappointed they have not responded in time.

Background Information

HMP Littlehey

16. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are convicted of sexual offences.
17. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. Prior to April 2015, Cambridgeshire and Peterborough NHS Trust provided healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care. Prisoners with lifelong conditions were identified effectively and nurses with additional specialist training provided relevant clinics. There was excellent and compassionate joint working between the healthcare provider, prison and community services for prisoners with palliative care and end-of-life needs.

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 January 2016, the IMB reported that the transfer to a new healthcare provider in April 2015 went smoothly with no adverse impact on service delivery.
20. The Board recognised the significant demands the elderly prison population made upon healthcare services, in particular the increasing number of hospital escorts, subsequent stays and the resulting risks associated with the redeployment of staff. They also expressed concern about future funding.

Previous deaths at HMP Littlehey

21. Mr Robinson was the tenth person to die from natural causes since January 2016. There were no significant similarities with the circumstances of the previous recent deaths.

Findings

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

22. On 24 July 2014, Mr Philip Robinson was sentenced to nine years imprisonment and was transferred to HMP Littlehey on 4 September. On arrival, he had no significant health problems other than some mild arthritis to his knees. His observations were within normal range and his weight noted at 68kgs. Mr Robinson smoked cigarettes heavily. Healthcare staff regularly advised Mr Robinson about smoking cessation, which he declined until he stopped smoking in September 2016.
23. On 5 August 2015, Mr Robinson saw a nurse for an older persons review. He was well and his observations were within normal range. He weighed 70 kgs. Mr Robinson again declined smoking cessation advice.
24. A prison GP saw Mr Robinson on 11 April 2016. He complained of suffering from a hoarse voice with occasional blood in his sputum. His weight was noted to be 69kgs. Mr Robinson's observations were within normal range, his throat was clear and there were no abnormal chest sounds. An acute lower respiratory infection was diagnosed. The GP referred him for an urgent chest x-ray, planned a review in two weeks and prescribed an antibiotic.
25. On 27 April, a prison GP saw Mr Robinson and told him the x-ray showed a hilar node. (A radiographic term that describes the enlargement of mediastinal lymph nodes and is most commonly identified by a chest x-ray.)
26. The GP arranged for an urgent CT scan, blood tests and a chest review. The GP told Mr Robinson that he might have cancer but full medical investigations were needed before any diagnosis could be made.
27. A prison GP reviewed Mr Robinson's blood test on 28 April and identified an abnormality. The GP made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
28. On 13 May, after a CT scan, a prison GP saw Mr Robinson with a nurse. The GP told Mr Robinson the scan indicated suspected lung cancer and referred him to a chest consultant. Mr Robinson told the doctor he would tell his family himself and at this stage did not want prison staff to be told. The nurse supported Mr Robinson as his named nurse, alongside healthcare staff.
29. Mr Robinson saw a consultant chest specialist at hospital on 18 May. The consultant confirmed that Mr Robinson had a potentially cancerous growth on his lung and requested further tests.
30. On 8 June, Mr Robinson saw a prison GP. The GP told Mr Robinson that he had cancer in his heart and lungs. Following the discussion, Mr Robinson signed A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, that in the event of cardiac or respiratory arrest no attempt at resuscitation would be made. All other appropriate treatment and care would continue to be provided.

31. Prison GPs referred Mr Robinson to a specialist in a timely manner using the two week system once they suspected he had cancer. The cancer diagnosis was made promptly.

Mr Robinson's clinical care

32. On 9 June, Mr Robinson went to the oncology clinic at hospital. The oncologist offered palliative chemotherapy, and prescribed a course of four treatments.
33. Mr Robinson chose to cancel the DNACPR on 15 June, as he wanted to be resuscitated if his heart or breathing stopped. He started chemotherapy on 16 June. On 29 June, a nurse and Mr Robinson developed his advanced care plan including a soft diet and protein milkshakes to provide added nutrition.
34. On 18 August, Mr Robinson went to the oncology clinic before his final cycle of chemotherapy. A CT scan showed some improvement to his condition.
35. Mr Robinson's records show he stopped smoking around 6 September. He found it difficult to eat following his final chemotherapy treatment, and doctors prescribed medication to increase his appetite. Radiotherapy scheduled to start on 14 September was delayed because Mr Robinson developed a chest infection.
36. On 19 September, Mr Robinson started a course of radiotherapy which he completed on 11 October.
37. Mr Robinson saw a prison GP on 4 November. He complained of coughing up blood, of having poor hand co-ordination, and of discomfort when eating. She referred Mr Robinson back to the consultant and prescribed medication to aid his digestion. He continued to be monitored by healthcare staff.
38. The nurse manager wrote in Mr Robinson's medical record that a consultant palliative care specialist from a hospice would be visiting Mr Robinson. The results of a recent scan indicated a spread of cancer cells to his brain and pancreas.
39. On 25 November, Mr Robinson fell in his cell and was sent to hospital. He returned to Littlehey a few hours later.
40. Around 3pm on 26 November, a nurse was called to Mr Robinson's cell by wing staff concerned for his health. She took Mr Robinson's medical observations which were poor, and noted he had slurred speech. She arranged to admit Mr Robinson to hospital.
41. Following a discussion with hospital staff, Mr Robinson signed a DNACPR form on 27 November. On 29 November, Mr Robinson was transferred to a hospice. He died at 2.20pm on 2 December.
42. The clinical reviewer noted that Mr Robinson's wishes were considered at all times, including his resuscitation wishes. Healthcare staff in the prison supported him to attend his treatments in hospital and the healthcare team managed the oral chemotherapy. They identified appropriately when he needed end of life care.

43. A number of care plans were created to support Mr Robinson through his illness. However, there was no care plan made for undergoing chemotherapy. Chemotherapy increases the likelihood of infections, which can delay treatment. Daily temperature checks would identify if Mr Robinson was suffering from an infection, and we would expect routine temperature checks. There was no record this had been done when Mr Robinson developed a chest infection in September 2016, which delayed radiotherapy treatment. Although this did not affect the outcome for Mr Robinson whose cancer was advanced, we agree with the clinical reviewer's recommendation that:

The Head of Healthcare should ensure all prisoners undergoing chemotherapy have a care plan to reflect the specific needs of the individual.

44. The clinical reviewer noted that the care Mr Robinson received was equivalent to what he could have expected to receive in the community, and in line with national guidelines.
45. A coroner's report noted that Mr Robinson died of natural causes from metastatic lung cancer (lung cancer which had spread to other parts of his body).

Mr Robinson's location

46. Mr Robinson was located in a single cell on D wing supported by prisoners and staff. Mr Robinson asked for a move to a prison nearer to his home following his diagnosis but accepted that if this was not possible, he would like to remain at Littlehey. (The nearest prison to Mr Robinson's home with appropriate healthcare facilities was a high security prison which would have been inappropriate for a category C prisoner such as Mr Robinson.)
47. On 25 November, healthcare staff offered Mr Robinson a cell on another wing, with a hospital bed and en suite facilities. He declined the offer so he could stay on his usual wing where he was comfortable and supported. Allowing him to remain there in line with his wishes meant he maintained his dignity and independence until his transfer to hospice care, which was also in accordance with his wishes.

Restraints, security and escorts

48. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
49. Mr Robinson had some mobility and managed to walk small distances; for longer distances he used a wheelchair. Healthcare risk assessments did not object to the use of restraints, which were removed for medical investigations and treatments. An escort chain was used for those visits. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

50. No restraints were used when Mr Robinson was admitted to hospital on 26 November. An escort of two officers supported Mr Robinson until he died.

Liaison with Mr Robinson's family

51. On 8 June 2016, a family liaison officer and a deputy family liaison officer met Mr Robinson to offer support and advice following his cancer diagnosis. Later that day, the officers spoke to Mr Robinson's next of kin, his wife. The officers arranged a visit for her and Mr Robinson's step-daughter, to visit him on 12 June.
52. The officers kept in regular contact with both Mr Robinson and his wife over the following months.
53. On 26 November, the officer telephoned Mr Robinson's step-daughter to tell her that her step-father had been admitted to hospital. The officer arranged open visiting for Mr Robinson's wife and her family at the hospital, and then at the hospice.
54. Mr Robinson's wife and grandson were at his bedside when he died. The officer and another family liaison officer met Mr Robinson's wife and grandson at the hospice to offer their support.
55. A funeral service was held on 29 December 2016. The prison paid towards the funeral expenses in line with national policy.

Compassionate release

56. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
57. A compassionate release application was completed in August 2016 and forwarded to NOMS for their consideration. The application was declined on 5 September as there was no firm prognosis.
58. When Mr Robinson was admitted to hospital on 27 November, although terminally ill, there was still no firm prognosis. The transfer to the hospice was in line with Mr Robinson's wishes. Without a prognosis another application for release would have been unlikely to be successful, and it is appropriate that one was not made.

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