Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Antony Robinson a prisoner at HMP Garth on 11 January 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Robinson died on 11 January 2017 at HMP Garth of peritonitis caused by a perforated duodenal ulcer. He was 49 years old. We offer our condolences to Mr Robinson's family and friends.

This is a very troubling case, revealing multiple individual and systemic failings by healthcare staff. I consider that the standard of care Mr Robinson received at Garth was well below that which he could have expected to receive in the community.

Mr Robinson was referred to the colorectal specialist at the hospital in July 2016 but no action was taken to follow this up and had still not been seen by the time he died six months later. As a result, an opportunity was clearly missed for Mr Robinson to access diagnosis, treatment and monitoring at an earlier stage.

Mr Robinson repeatedly reported severe abdominal pain and was managed under self-harm and suicide procedures after he threatened to kill himself to put an end to the pain. Prison officers and other prisoners expressed concern about him to healthcare staff. I find, however, that healthcare staff failed to recognise a clear decline in Mr Robinson's condition and that his repeated reports of pain were not treated with sufficient urgency or compassion. Nursing staff also routinely failed to refer Mr Robinson to the GP, and follow up reviews were not performed or chased up.

I am also concerned that the nurse designated as the emergency healthcare responder failed to hear the emergency call on the radio when Mr Robinson was found unresponsive in his cell, and neglected to seek confirmation despite hearing that medical assistance was required.

I draw my concerns to the attention of both the Executive Director, Long Term and High Security Estate and the NHS England Commissioners, and consider that disciplinary action may be warranted against some healthcare staff.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. On 24 August 2015, Mr Antony Robinson was convicted of violent crimes and sentenced to 16 years imprisonment. He was initially sent to HMP Durham but was later transferred to HMP Garth in March 2016.

2. Mr Robinson's initial health screen at Garth revealed no physical health concerns or outstanding medical appointments.

3. On 12 June, a nurse saw Mr Robinson after he reported abdominal pain, rectal bleeding and vomiting. The nurse requested a GP review but this was not carried out. On 24 July, a GP examined Mr Robinson and found nothing unusual but referred him to a hospital specialist. An initial appointment was cancelled by the hospital, and two other dates were declined by the prison. Mr Robinson was never seen by the hospital as a result.

4. On 6 November, a nurse saw Mr Robinson after he complained of chest pain, persistent vomiting and nausea. She requested a GP review for the following day, but, again, this did not take place. Mr Robinson continued to complain of illness and, on 2 December, a GP reviewed him. The GP recorded his history of abdominal pain, nausea and vomiting, and suspected a duodenal ulcer caused by a bacterial infection. On 7 December, test results confirmed this and, on 16 December, the GP gave Mr Robinson a seven-day course of medication with a note to review him in two weeks if this had not resolved the problem.

5. On 29 December, Mr Robinson was placed on an ACCT, a process designed to identify and care for prisoners at risk of suicide or self-harm. This was because he had threatened suicide or self-harm due to his ongoing health problems. At a review the next day, he stated that he constantly thought of self-harm or suicide because of the pain. A mental health nurse booked a GP review for two days later but this was cancelled by another nurse and rebooked for five days later.

6. On 6 January, a GP reviewed Mr Robinson and noted his history of abdominal pain, rectal bleeding and 'coffee ground' vomit. He examined Mr Robinson and noted discomfort, but was unable to perform a rectal examination. He recorded Mr Robinson's cancelled hospital appointment, and referred him to a specialist.

7. The next day, a nurse saw Mr Robinson as an emergency case. She noted that his blood pressure and pulse were high but thought this was due to his pain. She recorded that all other observations were normal, so gave him paracetamol and told him to take on fluids. She later noted that she thought he was drug-seeking.

8. On 10 January, a nurse saw Mr Robinson as an emergency but refused to treat him because she considered he was aggressive. An officer later took Mr Robinson to a GP. A nurse gave the GP a summary of Mr Robinson's medical history. The GP diagnosed psychogenic hyperventilation (over-breathing due to psychological factors). He later said that he had been influenced by the nurse's summary.

9. On 11 January, at 8.10am, officers unlocked Mr Robinson's cell. An officer saw he was gasping for breath so stayed with him briefly to help him control his breathing. All the cells were then locked until, at 9.10am, a different officer unlocked Mr Robinson's cell but could not fully open his door. An officer called an emergency on the radio, then got into Mr Robinson's cell, where he discovered him unresponsive. He immediately started cardiopulmonary resuscitation (CPR).

10. The designated emergency response nurse heard a call on the radio but said she did not recognise it as an emergency. She said she had seen Mr Robinson the day before and was wary of going to his cell unescorted. She waited with her colleague for an officer but said she attended as soon as she realised it was an emergency. Healthcare staff took over CPR. After about 15 minutes, paramedics arrived and took over but at 9.57am, pronounced Mr Robinson dead.

11. A post-mortem report concluded that the cause of Mr Robinson's death was peritonitis caused by a perforated duodenal ulcer.

Findings

Mr Robinson's clinical care

12. Overall, we find that the standard of clinical care Mr Robinson received at Garth fell well below that which he could have expected to receive in the community.

13. Systematic and procedural healthcare failings meant that the referral for a specialist hospital appointment never happened, and multiple GP reviews and health clinics were also missed and not followed up.

14. We also share the concerns of the clinical reviewer that the healthcare staff lacked clinical judgement in their dealings with Mr Robinson. We find that there was a failure to recognise a clear decline in his condition and that his reports of pain were not treated with sufficient urgency or compassion. We consider that healthcare staff incorrectly attributed his requests for pain killers to drug-seeking or other factors. Nursing staff routinely failed to refer Mr Robinson to the GP, and follow up reviews were not performed or chased up.

15. We also find that there was a lack of communication and teamwork between healthcare staff, and a failure by healthcare staff to review Mr Robinson's medical history properly before making judgements. The quality of his medical records was poor, and there was no adequate audit trail to ensure referrals were not repeatedly missed.

Emergency response

16. We are concerned that the designated emergency healthcare responder failed to react with sufficient urgency when the emergency was called on the radio. We find it troubling that she failed to seek confirmation despite hearing that medical assistance was required. While we have no evidence that she deliberately ignored the call, we would have expected her, as the person designated as the emergency healthcare responder, to be within clear earshot of the radio and primed to deal with an emergency.

17. We are satisfied that CPR was started promptly by an officer, once Mr Robinson was found unresponsive. Although we are concerned that CPR was stopped after a brief period, we accept that staff believed that Mr Robinson had showed signs of breathing, and that fluid was coming out of his mouth. In these circumstances, we accept that the senior officer made a reasonable judgement to place Mr Robinson in the recovery position to prevent his choking. We also acknowledge that this situation was monitored and CPR was about to be restarted when healthcare staff arrived and took over.

Family contact

18. We are satisfied that the prison acted appropriately in their contact with Mr Robinson's family.

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, and that if they are missed, they are rescheduled without delay.
- The Head of Healthcare should ensure that systems are in place to ensure that prisoners are notified of GP or clinic appointments, and to ensure processes are in place to reschedule medical appointments that have been missed.
- The Head of Healthcare should ensure that prisoners are promptly referred to a GP when necessary, and that follow-up reviews are conducted without delay.
- The Head of Healthcare should ensure that all healthcare staff are fully aware of their role and responsibilities, and that they are competent to make accurate clinical judgements.
- The Head of Healthcare should ensure that healthcare staff communicate effectively to ensure that prisoners receive appropriate continuity of healthcare.
- The Head of Healthcare should ensure that all important information about prisoners' health is entered on SystmOne and that healthcare staff adequately review SystmOne records to ensure appropriate continuity of care.
- The Head of Healthcare should ensure that all healthcare staff are aware of and understand their responsibilities during medical emergencies, and that designated emergency responders are able to hear and respond to emergency codes without delay.
- The Executive Director, Long-Term and High Security Estate and the NHS England Commissioners, should assure themselves that:
    - effective action is taken to address the findings of this investigation;
    - disciplinary action is initiated against healthcare staff where warranted; and
    - the recommendations in this report are promptly and effectively implemented.

The Investigation Process

19. The investigator, issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. Several prisoners responded and indicated they would like to speak to him when he visited.

20. He visited Garth on 19 January 2017. He obtained copies of relevant extracts from Mr Robinson's prison and medical records. He also conducted interviews with 10 members of staff and 11 prisoners by group interview and individually.

21. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison. Between 10 and 22 February, the investigator and the clinical reviewer conducted interviews with six members of staff and five prisoners individually.

22. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. One of the Ombudsman's family liaison officers, contacted Mr Robinson's mother and step-father to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They asked us to consider:

    - Mr Robinson's health complaints and the clinical care he received;
    - the circumstances in which he was found; and
    - the emergency response.

    They also had specific questions about his diagnosis, test results, treatment and weight loss, and how he was monitored and managed.

24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

25. Mr Robinson'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.

Background Information

HMP Garth

26. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. At the time of Mr Robinson's death, Lancashire Care Foundation Trust provided health services. Nurses were on duty between 7.00am and 9.00pm every day. Chorley Medics provided a service outside these times. GP clinics were held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There was no in-patient unit. Garth were due to change healthcare providers in April 2017.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Garth was conducted in January 2017. Inspectors reported that the range of primary healthcare clinics was appropriate but, at around 5 weeks, waiting times were unacceptably long for GP appointments. Prisoners with urgent health needs were seen promptly and access to the community out-of-hours GP service was appropriate. Prisoners with acute health needs or injuries could access daily nurse assessment clinics.

Independent Monitoring Board

28. 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 30 November 2016, the IMB at HMP Garth reported that GP waiting times had reduced from 4-5 weeks to 3 weeks. There were also fewer missed hospital appointments from lack of escorts, because of the attendance at the establishment of a Medical Mobile Unit which was used for CT Scans/X Rays/MRI Scans and Ultra Sound appointments.

Previous deaths at HMP Garth

29. Mr Robinson was the third prisoner to die of natural causes at Garth since January 2016. We have previously made recommendations relating to clinical care.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Key Events

31. On 24 August 2015, Mr Antony Robinson was convicted of violent crimes and sentenced to 16 years imprisonment. He was initially sent to HMP Durham, but on 31 March 2016 was transferred to HMP Garth.

32. When he arrived at Garth, a nurse reviewed Mr Robinson at a reception health screen. He had no physical health concerns and no outstanding medical appointments, although an allergy to ibuprofen was noted.

33. On 18 May, a nurse saw Mr Robinson following complaints of sharp abdominal pains and headaches when he opened his bowels. He booked Mr Robinson in for blood tests the following week, and for a GP review. Mr Robinson did not attend the blood clinic, but no reason was given in his medical records.

34. On 31 May, a prison GP, reviewed Mr Robinson. He examined Mr Robinson's chest and abdomen but found them unremarkable. He gave Mr Robinson paracetamol, and requested blood tests with a further review following these results. On 6 June, Mr Robinson failed to attend the blood clinic appointment but no reason was given and no further appointment was made.

35. On 12 June the Head of Healthcare, saw Mr Robinson, after he complained of abdominal pain, rectal bleeding and vomiting. Mr Robinson said that when he woke up, he saw blood on his sheets and in his underpants. He noted that Mr Robinson's clinical observations were unremarkable but he requested a GP appointment for the next day. However, Mr Robinson was not reviewed by a GP as planned. In interview, the Head of Healthcare said that this request was not processed by the admin team. The appointment appeared to still be active on the GP ledger, which suggested that Mr Robinson was never called to attend.

36. On 23 July, a nurse saw Mr Robinson after he reported rectal bleeding during the night. She performed a full blood test and planned for a GP referral. Later that day, a prison GP, recorded that Mr Robinson's blood test results were borderline, and noted that a repeat test was required "in a week or so". There is no record of a repeat test taking place. Mr Robinson's medical records show that he failed to attend an appointment at the blood clinic on 19 August, but no reason was given and no fresh appointment was made. In interview, the Head of Healthcare said that Mr Robinson should have received an appointment letter for this clinic but this did not appear to have happened. He added that if an appointment letter had been sent, Mr Robinson would not have been recalled for a further appointment.

37. On 24 July, a prison GP, reviewed Mr Robinson. Mr Robinson told the prison GP that he had had a similar problem in the past but after a biopsy and camera test had been told that everything was normal. The prison GP examined Mr Robinson's abdomen and found nothing unusual but noted that he had severe piles. The prison GP referred him to the colorectal specialist at hospital. An appointment was made for 11 October but this was cancelled by the hospital. The hospital then offered two further dates which were declined by the prison. No reasons were recorded and no date was ever set for this appointment.

38. On 6 November, a nurse reviewed Mr Robinson after he complained of vomiting and chest pains. Mr Robinson told her that he vomited every night and had done so for the past month. He added that his bowels only opened every few days, and he was eating less due to nausea. She recorded that Mr Robinson's clinical observations and an ECG test were normal. She instructed Mr Robinson to rest and to drink plenty of fluids. She recorded that he was to be reviewed the next day by a GP. Mr Robinson was not reviewed.

39. Four days later, a nurse saw Mr Robinson after wing officers expressed their concern about him still being sick. She examined him and recorded that his clinical observations were normal. She noted that he "has been seen now 3 times in a week and nil acute presentation or findings on either of the 3 appointments". She declined to issue a sick note, and advised Mr Robinson to apply for a GP appointment. She recorded: "He is agitated so I've opened the door and indicated that he [should have] left."

40. On 24 November, Mr Robinson called the healthcare unit complaining of vomiting and nausea. A nurse spoke to him on the phone, and advised him to remain in his cell behind the door for 48 hours but to use his cell bell if he needed anything.

41. On 2 December, a prison GP reviewed Mr Robinson following his history of abdominal pain, nausea, vomiting and a headache and light headedness. He examined Mr Robinson's abdomen, but found nothing unusual. He recorded that he suspected a duodenal ulcer (a sore occurring in damaged intestines) caused by H. pylori bacteria. (Helicobacter pylori are bacteria that grow in the digestive tract and can attack the stomach lining.) The prison GP requested a stool sample to confirm this and prescribed Mr Robinson with medication to reduce the acid in his stomach and to prevent sickness.

42. On 7 December, the test results confirmed that Mr Robinson had H. pylori. On 16 December, a prison GP saw Mr Robinson and started him on a seven-day course of triple therapy treatment (two types of antibiotics and an antacid – commonly used to treat H. pylori). He noted that he would review Mr Robinson two weeks later if it had not settled.

43. On 29 December, a nurse performed a triage assessment over the telephone with Mr Robinson due to his continued vomiting. She advised him to remain in his cell for 48 hours, and to fast or eat a light diet while drinking plenty of fluids. In interview, she said that this was standard procedure where there is a risk of infection. There is no record of a follow up to this.

44. Later that day, an officer opened an ACCT for Mr Robinson. The officer recorded that "Antony has some ongoing health problems which he said are driving him mad". He added: "He said he was having thoughts of harming himself by either cutting or hanging himself."

45. On Friday 30 December, an officer assessed Mr Robinson as part of the ACCT process. She recorded that "Antony stated his main problem is his ongoing medical problem – chest pains/abdomen pains and piles." She added: "Antony constantly has thoughts of self-harm/suicide because he wants the pain to stop." A little later, Mr Robinson had an ACCT review, with a colleague and the officer, along with two mental health nurses and someone from the prison chaplaincy. A

care map was drawn up, with a nursing colleague tasked to arrange a GP appointment urgently. In interview, the nurse told us that she noticed there was a GP clinic that Sunday, 1 January, and used the online GP ledger to book Mr Robinson in for that. She added that mental health nurses were not supposed to do this but it was urgent. On 1 January, however, another nurse cancelled this appointment and rebooked it for a regular GP clinic on Friday 6 January.

46. On 2 January, Mr Robinson had a further ACCT review with an officer and a mental health nurse. After the review, the mental health nurse sent an electronic request for pain relief for Mr Robinson but was told by the prison GP that Mr Robinson should wait for his GP appointment, or speak to a GP.

47. On 5 January, a nurse spoke to Mr Robinson on the telephone after he complained of pains in his side and that he could not get out of bed. She told him that this did not warrant an immediate GP review or require him to visit healthcare. She noted his pending GP appointment and advised Mr Robinson to wait for this, but to use his cell bell if he became unwell. She declared Mr Robinson fit for work.

48. On 6 January, a prison GP reviewed Mr Robinson. He noticed that Mr Robinson's hospital appointment for rectal bleeding had been cancelled, and that Mr Robinson had lost 8kg in weight, and 11.6kg in total over the past 24 months. He recorded Mr Robinson's history of abdominal pain, 'coffee grounds' vomit after eating, and a small amount of blood in his stool. He examined Mr Robinson's abdomen and noted generalised discomfort, but was unable to perform a rectal examination because Mr Robinson could not relax. He referred Mr Robinson to the gastroenterology service at the hospital, but there is no indication that this was an urgent referral.

49. At the same consultation, a prison GP recorded that Mr Robinson had been using illicit drugs on the wing, and referred him to the IDTS (integrated drug treatment service). (It is not clear where this information came from.) He also diagnosed Mr Robinson with depression and prescribed him anti-depressants.

50. On 7 January, a nurse recorded that she was called to see Mr Robinson as a code blue emergency. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) She recorded that Mr Robinson had vomited earlier and was suffering with chest pain. She observed that his blood pressure and pulse were high, but noted that this could be due to his pain. She recorded that all other observations were within normal limits. She gave him a dose of paracetamol and advised him to drink plenty of water but not to eat. In interview, she said: "He did look like he was in pain, yeah. He was tachycardic [an increased heart rate of more than 100 beats per minute]. He was hunched up and he did look in discomfort."

51. Later that day, the same nurse made a belated entry in Mr Robinson's records: "Further to my entry of 12.04 today I would like to add that I got the impression that this patient was drug seeking". In interview, she told us that, after consideration, she had made this addition to his medical records because "the impression I got from him, it was really strong". She told us that she "did think he was in pain… but you don't … expect somebody with that kind of chest pain and

that kind of vomiting to start screaming at you that paracetamol's not good enough". There are no entries in Mr Robinson's prison record relating to drug taking during his time at Garth.

52. On 9 January, Mr Robinson had an ACCT review with a nurse and an officer. The nurse agreed to liaise with physical health nurses about pain relief and to chase up Mr Robinson's IDTS referral. Mr Robinson remained on an ACCT, and was on hourly checks.

Events of 10 January

53. On 10 January, just after 12.30pm, Mr Robinson told an officer his stomach was giving him a lot of pain. In interview, he said that, at the time, Mr Robinson was standing in his cell speaking to him, so he completed his duties and then telephoned the healthcare unit a couple of times, but did not get an answer. He told us that at about 12.45pm, multiple cell bells sounded on Mr Robinson's landing, and several prisoners were banging on their cell doors. He said he returned to the wing, and that prisoners were saying, "He's in a lot of pain" and "He's dying". An officer observed Mr Robinson bent over his bed repeating that he was in pain. He called a code blue emergency.

54. Shortly afterwards, a nurse arrived, with a student nurse and two prison officers. In interview, the nurse said that when she entered Mr Robinson's cell, "he was on all fours on his bed with his head down". She added that she asked him to sit up so she could examine him, but he started shouting and swearing at her. She said that Mr Robinson then jumped off the bed, so she retreated from his cell and said she would not treat him while he was being aggressive, but that he could see the GP later if he calmed down. She added that she did not think Mr Robinson was in so much pain because of the way he got up quickly. The officer who called a code blue emergency, told us in interview that Mr Robinson was swearing and shouting, but he said, "Personally I didn't see him as a threat, because he was kind of bent over his bed, holding his stomach." Mr Robinson had no adjudications for violence to staff or prisoners during his time at Garth.

55. Around 1.30pm, several prisoners on Mr Robinson's landing expressed their concern about him to a second officer. They refused to attend work until Mr Robinson was seen. In interview, a prisoner, said that he went to get help as soon as he was unlocked after lunch. He said he told officers, "He weren't being aggressive, he's in agony… if you was in agony and trying to talk it'll come out as aggressive." The officer spoke to the nurse on the phone but she refused to see Mr Robinson in his cell because of his earlier behaviour. She agreed that Mr Robinson could see the GP at the end of his clinic that day. Mr Robinson was unable to walk so the officer and several prisoners carried him up two flights of stairs in a wheelchair before he and another officer wheeled him into the GP.

56. A prison GP saw Mr Robinson at short notice. The nurse provided him with a summary of Mr Robinson's clinical history prior to the consultation. The prison GP noted that Mr Robinson had experienced abdominal pain, back pain and shoulder pain. He had been lying on the floor clutching his abdomen or on all-fours, and had been struggling to breathe. The prison GP noted Mr Robinson's anxiety and that he was on an ACCT, but the doctor told us in interview that he was not aware the ACCT had been put in place because of Mr Robinson's

physical pain. He examined Mr Robinson and observed that he moved freely, had no apparent discomfort and his abdomen was soft but with no tenderness. He diagnosed psychogenic hyperventilation (over breathing caused by psychological factors). He prescribed antacid medication but Mr Robinson never collected this. In interview, the prison GP told us that the case history provided by the nurse had influenced his diagnosis.

Events of 11 January

57. On 11 January at 8.10am, two officers unlocked Mr Robinson's cell as part of the usual morning unlock procedure. One of the officers checked on Mr Robinson and observed that he was gasping for breath. He was worried that Mr Robinson was panicking and making his pain worse. In interview, he said that he remembered what the GP had said and encouraged Mr Robinson to breathe steadily through his nose to prevent hyperventilation. He said that this seemed to help so, after 10–15 seconds, he left to complete his rounds and told Mr Robinson he would come back soon to check on him. Two prisoners who were resident in adjacent cells, and said in interview that they kept checking on Mr Robinson until they went off to work. An officer returned a little later to lock Mr Robinson's cell, and reminded him to use his cell bell if he had any problems.

58. At 9.10am, an officer unlocked Mr Robinson's cell to perform routine checks. He said that he could only open the door about two feet, and realised that Mr Robinson was lying on the floor, blocking the door. He was unable to get through the narrow gap so he called a colleague who was unlocking the cells opposite. The second officer immediately called a code blue on the radio then squeezed through the gap in the doorway into Mr Robinson's cell. He noticed that Mr Robinson had fallen, with his head wedged in the corner of the door, preventing it from opening. He slid Mr Robinson away from the door to enable the door to open but could get no response from him. The first officer was unable to find a pulse so the second officer started CPR. In interview, he said that after ten compressions Mr Robinson gasped. At this point, a Supervising Officer (SO) arrived having heard the code blue call. In interview, she said that she could see Mr Robinson on the floor with fluid coming out of his mouth. She told them to put him in the recovery position because he was still making noises and was visibly breathing, although clear fluid was coming from his mouth. She reiterated on the radio that it was a code blue, and that an ambulance would be required.

59. The nurse who had previously entered Mr Robinson's cell, was the emergency medical responder on duty that day. In interview, she told us that she heard a call for medical assistance on the radio and acknowledged this, but did not realise it was a code blue emergency. She also said that she requested assistance because she was wary of going on to the wing after what had happened the day before. While she was waiting for an officer near the wing with another nurse, a prisoner approached and told them Mr Robinson was not breathing. She told us that she said that it was a code blue, and that they did not have the emergency bag. By that point, a healthcare assistant, had joined them, having heard the code blue call on the radio. The nurse said they set off to Mr Robinson's cell, and she asked the healthcare assistant to collect the code blue emergency bags because they did not have them. Another nurse arrived at Mr Robinson's cell shortly afterwards and was assessing Mr Robinson when the

nurse who was the emergency medical responder arrived, approximately 15 seconds later.

60. The supervising officer said that the second nurse arrived shortly after she had asked for Mr Robinson to be put in the recovery position. She said that they both realised that Mr Robinson had stopped breathing so she asked the officers present to bring him out on to the landing. The nurse said that she could not find any signs of breathing or a pulse, so she began CPR. The other healthcare staff arrived shortly afterwards with the emergency bag, and the emergency medical responder nurse connected with the defibrillator. She said that the defibrillator gave a shock on one occasion, and they rotated the cycle of CPR until the paramedics arrived and took over.

61. The incident log noted that the code blue was called at 9.05am, with the ambulance being requested at the same time. At 9.21am, the first ambulance arrived, and at 9.33am, the second ambulance arrived. At 9.57am, paramedics pronounced Mr Robinson dead.

Prisoners' concerns about Mr Robinson's healthcare

62. Several prisoners expressed their concern to us about Mr Robinson's healthcare in the months leading up to his death. In interview, one prisoner said that Mr Robinson had been vomiting through the night for several weeks, if not months. He added, "I watched him waste away. Over a few months really, but really from the Friday." Another prisoner told us that Mr Robinson first became ill the previous autumn but that he deteriorated just before Christmas. In interview, he stated that he reported to healthcare staff that Mr Robinson was losing weight, getting pains in his chest and had rectal bleeding. He added "They're telling me that they've seen him go from 17 and a half stone to 10 and a half stone in the space of three month and tell me that man is healthy." A third prisoner told us in interview that "two weeks before he died, [Mr Robinson] was that bad he wanted to slash his wrists to get to the hospital for help, and we talked him out of it". He also said that Mr Robinson had lost about four stones in his last four weeks.

Contact with Mr Robinson's family

63. Mr Robinson's next of kin was his mother. On 11 January 2016, the prison appointed custodial manager as his family liaison officer. At 1.10pm, he and a member of staff from the prison chaplaincy visited Mr Robinson's mother's home. Mr Robinson's step-father answered the door and told them that his wife was at work. He telephoned her and she arrived home at 1.30pm. The family liaison officer and prison chaplaincy staff informed her of the death of her son, and offered their support.

64. Mr Robinson's funeral was held on 30 January. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

65. After Mr Robinson's death, the Duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Three

officers who had had dealings with Mr Robinson were not present at the hot debrief, but were spoken to separately.

66. The prison posted notices informing other prisoners of Mr Robinson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Robinson's death.

Post-mortem report

67. The post-mortem concluded that Mr Robinson's cause of death was peritonitis caused by a perforated duodenal ulcer. The pathologist stated that histological findings indicated that the ulcer had been present for some time, but she could not state accurately when the ulcer perforated.

68. Toxicological tests were performed and the pathologist confirmed that the only substances present were prescribed drugs at a therapeutic level. She confirmed that these drugs played no role in Mr Robinson's death. She also recorded that there was no evidence of any illicit drugs being present.

Findings

Mr Robinson's clinical care

69. The clinical reviewer concluded that the care Mr Robinson received at Garth was substandard and not equivalent to that which he could have expected to receive in the community. Although we recognise that Garth faced healthcare staffing issues at the time and were heavily reliant on agency staff, we share the clinical reviewer's concerns about the catalogue of failures in the care given to Mr Robinson.

70. We agree with the clinical reviewer that there were no adequate systems in place to ensure that specialist appointments were properly managed and chased up. Mr Robinson was referred to the colorectal specialist at the hospital in July 2016 but had still not been seen by the time he died six months later. We accept that the hospital initially cancelled this appointment, but it offered the prison a further two dates which were declined for reasons which have not been recorded. In such circumstances, it becomes the duty of prison healthcare to reschedule the appointment, but this was not done. As a result, an opportunity was clearly missed for Mr Robinson to access diagnosis, treatment and monitoring at an earlier stage.

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, and that if they are missed, they are rescheduled without delay.

71. We are also concerned that during the summer of 2016, when Mr Robinson failed to attend the blood clinic on three separate occasions, no reasons were given and no fresh appointment made. Head of Healthcare, accepted that no appointment letter was produced for these and that the appointments would therefore not be followed up in these circumstances. Mr Robinson also failed to attend for a GP review on 13 June, despite being referred the day before by the Head of Healthcare. This request was not processed by the admin team at the time, so Mr Robinson was never called for this review. This appointment was also never followed up and the Head of Healthcare said that it was still active on the GP ledger at the time of his interview on 22 February 2017.

The Head of Healthcare at Garth should ensure that systems are in place to ensure that prisoners are notified of GP or clinic appointments, and to ensure processes are in place to reschedule medical appointments that have been missed.

72. There was also a failure by nursing staff to refer Mr Robinson to the GP, or to hold follow up reviews when he was presenting as very unwell. On 4 November, a nurse recorded that Mr Robinson should be reviewed by the GP the next day but this did not happen. We are also concerned that four days later, when the nurse who entered Mr Robinson's cell, saw Mr Robinson after concerns were raised by prison officers, she not only declined to refer him to a GP, she also refused to give him a sick note and asked him to leave when he became agitated. We accept that his clinical observations were normal at that time, but would have

expected a GP referral, especially considering that this should have happened a few days earlier.

73. Mr Robinson was finally seen by a GP, on 2 December, who suspected he had a duodenal ulcer and a bacterial infection in his digestive tract. Five days later, tests confirmed this, but it was not until 16 December that a prison GP saw Mr Robinson and started treatment. The prison GP also noted that he would review Mr Robinson two weeks later if the problem had not resolved. We are concerned that this review did not happen, and that healthcare staff did not seem aware that it should have. On 29 December, a nurse performed a telephone triage with Mr Robinson but neglected to send him for a GP review as requested by the prison GP less than two weeks earlier.

The Head of Healthcare should ensure that prisoners are promptly referred to a GP when necessary, and that follow up reviews are conducted without delay.

74. We share the concerns of the clinical reviewer, that healthcare staff at Garth lacked clinical judgement in their dealings with Mr Robinson. In addition to the vomiting, rectal bleeding and nausea, Mr Robinson also experienced rapid and unintentional weight loss, along with severe pain. He was placed on an ACCT at the end of December because he was threatening to harm himself due to the pain he was in. Fellow prisoners and prison officers also raised their concerns with healthcare staff. However, healthcare staff failed to take his condition seriously and attributed his requests for pain relief to drug-seeking or other reasons. We consider that this clouded their judgement and directly influenced their decisions about pain management and whether to refer him for urgent GP reviews.

75. When a nurse saw Mr Robinson on 7 January 2017, she recorded several worrying clinical observations, and accepted that he was clearly in pain, but she not only neglected to refer him to the GP, she belatedly recorded that he was drug-seeking. She also stated in interview that there were no GP clinics available over that weekend, but an emergency GP clinic does operate between 10am and 12pm on a Sunday. It is also significant that the prison GP told us that his diagnosis of psychogenic hyperventilation on 10 January, was influenced by the history summary given to him by the nurse who had seen Mr Robinson in his cell.

The Head of Healthcare at Garth should ensure that all healthcare staff are fully aware of their role and responsibilities, and that they are competent to make accurate clinical judgements.

76. We are also concerned about the lack of communication and teamwork between healthcare staff at Garth. Despite Mr Robinson being on an ACCT due to his pain, with the sole action point being that he saw a GP urgently, he did not see a GP for over a week. It is also worrying that an urgent GP appointment was made by a mental health nurse, only for it to be cancelled by a physical health nurse, with a further five-day wait for an alternative appointment.

77. The Head of Healthcare at Garth should ensure that healthcare staff communicate effectively to ensure that prisoners receive appropriate continuity of healthcare

78. While Mr Robinson was at Garth, his medical notes were inadequate and neither updated nor referred to appropriately. We agree with the clinical reviewer that healthcare staff appeared to treat him in isolation and did not refer to his history when forming their judgement. There was no clear audit trail for referrals, which made it impossible for treatment to be planned and carried out effectively. We also consider that this may help to explain the missed medical appointments.

The Head of Healthcare at Garth should ensure that all important information about prisoners' health is entered on SystmOne and that healthcare staff adequately review SystmOne records to ensure appropriate continuity of care.

Emergency response

79. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system in place. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and the emergency medical responder to attend with the necessary equipment and assess the patient.

80. We are satisfied that when prison officers discovered that Mr Robinson was unresponsive, a code blue was called immediately. It was heard by other officers, healthcare staff, and the communications room who called an ambulance straight away. However, we are concerned that the emergency medical response nurse did not respond with sufficient urgency to this emergency call, and neglected to take the emergency response bag with her. We are also concerned that healthcare staff initially waited for an officer to escort them onto Mr Robinson's landing.

81. While we have no evidence to doubt the emergency medical response nurse's insistence that she did not hear the code blue call on the radio, we find it extremely troubling that this could have happened. She was the designated emergency responder and we would, therefore, have expected her to be primed and ready to deal with any emergency arising at the prison. We would certainly have expected her to have been within earshot of the radio, and to have sought confirmation if the initial call had not come through clearly.

The Head of Healthcare at Garth should ensure that all healthcare staff are aware of and understand their responsibilities during medical emergencies, and that designated emergency responders are able to hear and respond to emergency codes without delay.

82. We are satisfied that CPR was started promptly by the officer who found Mr Robinson, once it was established that Mr Robinson was unresponsive. Although we are concerned that this was stopped after a brief period, we accept that staff believed Mr Robinson had showed signs of breathing, and that fluid was coming out of his mouth. In these circumstances, we are satisfied that the supervising officer made a reasonable judgement in instructing staff to place Mr Robinson in the recovery position to prevent him choking. We also recognise

that this situation was monitored, and that CPR was about to be recommenced when healthcare staff appeared and took over.

Family contact

83. Despite Mr Robinson's family living a long way from Garth, his family liaison officer arrived at his mother's home a little over three hours after his death. His mother was then informed in person and offered support. Staff at the prison facilitated a visit to the prison and offered their support throughout. We consider that the prison acted appropriately in their contact with Mr Robinson's family.

Follow up action and assurance

84. Given the seriousness of the issue we have identified, and the need for effective action to address our findings, we make the following recommendation:

The Executive Director, Long Term and High Security Estate and the NHS England Commissioners, should assure themselves:

- **that effective action is taken to address the findings of this investigation;**
- **that disciplinary action is initiated against healthcare staff where warranted; and**
- **that the recommendations in this report are promptly and effectively implemented.**

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141