

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Lewis, a prisoner at HMP Stafford, on 21 April 2020

**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 Lewis died on 21 April 2020 of metastatic small cell lung cancer while a prisoner at HMP Stafford. Mr Lewis was 67 years old. I offer my condolences to Mr Lewis' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Lewis received at Stafford was equivalent to that which he could have expected to receive in the community. She made three recommendations.
5. We found no non-clinical issues of concern.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendations

- **The Head of healthcare should ensure that there are systems in place to check compliance with prescribed medication especially for patients with known memory loss.**
- **The Head of Healthcare should ensure that syringe drivers are available for patients who need them in cell locations and that staff have appropriate training on how to use them in liaison with the local hospice.**
- **The Governor and Head of Healthcare should ensure that prisoners needing social care have appropriate assessments and services organised for them in a timely manner.**

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Lewis' clinical care at HMP Stafford.
8. The PPO investigator has investigated non-clinical issues, including Mr Lewis' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Lewis' next of kin, his sister, to explain the investigation. She asked why Mr Lewis had not had chemotherapy, details about his pain management, whether he had lost his sight and why, after 22 years in prison, he had not been released.

10. The clinical reviewer has addressed the clinical questions in her review and the issue of release has been addressed in this report.
11. Mr Lewis' family received a copy of the initial report. They did not make any comments.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

#### **Previous deaths at HMP Stafford**

13. Mr Lewis was the seventh prisoner to die at HMP Stafford since April 2018. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Lewis' death and our investigation findings for the previous deaths.

## Key Events

14. In 1995, Mr Robert Lewis was sent to prison for sexual offences and was released in 2007. He was recalled to custody four hours later for breaching his licence conditions. He was released again in November 2008. Within two months, Mr Lewis faced further charges and in 2009, he was sent to prison for further sexual offences. Mr Lewis transferred to HMP Stafford on 4 August 2009.
15. In 2012, the Parole Board refused Mr Lewis' release because of concern about his breach of trust and being unable to manage his impulsive behaviour. The Parole Board concluded that Mr Lewis should remain in closed conditions where his risk could be securely managed.
16. On 25 March 2019, Mr Lewis told a prison nurse that he had abdominal pain. She noticed his eyes and skin were yellow and referred him to a prison GP. A prison GP confirmed that Mr Lewis was jaundiced and arranged urgent blood tests. The blood test results showed that Mr Lewis had obstructive jaundice indicating that there was something blocking the outflow from his liver.
17. On 26 March, the prison GP arranged for Mr Lewis to have a fast-track hospital appointment for suspected upper gastrointestinal cancer at the County Hospital, Stafford.
18. In April and May, Mr Lewis had several hospital tests which included an MRI and PET-CT scan, and an ERCP (Endoscopic Retrograde Cholangiopancreatography). Hospital staff diagnosed primary lung cancer and secondary cancer in his pancreas and offered Mr Lewis chemotherapy. However, Mr Lewis said that he did not want to have any cancer treatment. Prison healthcare staff considered that he had the mental capacity to make decisions about his care and treatment.
19. On 20 January 2020, the prison GP increased Mr Lewis' morphine dose for better pain control and medication for his nausea and indigestion. A prison nurse noted Mr Lewis' deterioration and arranged for MacMillan nurses to visit him.
20. On 3 February, prison healthcare staff tried to talk to Mr Lewis about his wishes if his heart or breathing stopped under the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directive. The prison GP noted that Mr Lewis was unclear about his wishes. The Multiple Disciplinary Team discussed this and concluded that Mr Lewis lacked the mental capacity to understand DNACPR decisions and that there should be a discussion with his family about resuscitation. A prison nurse discussed this with Mr Lewis' sister on 6 February, who agreed with the decision not to attempt to resuscitate him in the event of an emergency as she did not want her brother to suffer. The GP signed the DNACPR order the following morning.
21. By 16 February, the prison GP noted Mr Lewis was deteriorating and that end of life care should begin. Healthcare staff obtained advice from Katherine House Hospice about how to manage Mr Lewis' deteriorating health. Healthcare staff also arranged for social care support and a dementia specialist nurse to visit Mr Lewis. They discussed his cognitive decline and the arrangements for him to be

admitted to the hospice or a palliative care bed at County Hospital for further pain management.

22. On 20 March, Mr Lewis told healthcare staff that he wished to stay at HMP Stafford for his care and that he felt well cared for.
23. On 20 April, Mr Lewis moved to Katherine House Hospice when his health deteriorated. At 2.40am on 21 April, it was confirmed that Mr Lewis had died.

#### **Cause of death**

24. The Coroner accepted the cause of death provided by clinicians as metastatic small cell lung cancer. No autopsy was carried out.

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**December 2020**

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**Annex 1 Mr Lewis' clinical review**

**Annex 2 HMPPS action plan**