

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Robin Geeves, a prisoner at HMP Moorland, on 18 February 2022**

**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

**OGL**

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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 Robin Geeves died from lung cancer (which had spread to other parts of his body) on 18 February 2022 in hospital while a prisoner at HMP Moorland. He was 71 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Geeves received at Moorland was of a good standard and equivalent to that which he could have expected to receive in the community.
5. The clinical review made two recommendations which did not relate to Mr Geeves' death, but which the Head of Healthcare will need to address.
6. We did not find any non-clinical issues of concern, and we make no recommendations.

## **The Investigation Process**

7. NHS England commissioned an independent clinical reviewer to review Mr Geeves' clinical care at Moorland.
8. The PPO investigator has investigated non-clinical issues, including Mr Geeves' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The Ombudsman's family liaison officer wrote to Mr Geeves' brother to explain our investigation. He raised an issue that was outside the remit of our investigation which we have addressed in separate correspondence.
10. We shared the initial report with the Prison Service. There were no factual inaccuracies.
11. We shared the initial report with Mr Geeves' brother. He did not respond.

## **Previous deaths at HMP Moorland**

12. In the two years before Mr Geeves' death, seven prisoners died from natural causes at HMP Moorland, one as a result of COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

13. In August 2017, Mr Robin Geeves was sentenced to ten years in prison for sex offences. On 11 December 2019, he was transferred to HMP Moorland.
14. On 18 November 2021, a nurse saw Mr Geeves in the healthcare unit because he had pain in his right shoulder. She noted that he was able to extend his arms.
15. On 2 December, Mr Geeves went back to the healthcare unit as his shoulder pain had continued and he suddenly collapsed. A nurse noted that while he was being monitored, Mr Geeves told her that he had no tightness in his chest and no pain, other than in his right shoulder. She arranged for an ambulance, but Mr Geeves' condition improved, and he was not taken to hospital.
16. On 31 December, a nurse saw Mr Geeves because he was short of breath and was coughing up blood. She carried out a full assessment and asked for an urgent chest x-ray. She prescribed antibiotics and an inhaler. A prison GP agreed with the nurse's management plan.
17. On 5 January 2022, a prison GP reviewed Mr Geeves and noted that the antibiotics had made no difference to his shortness of breath or cough. The GP noted his shoulder pain and asked for a sputum sample to be tested. The GP increased his pain relief and prescribed an antibiotic.
18. On 21 January, Mr Geeves had a chest x-ray which showed that he had a thoracic aorta (an abnormal bulge in the wall of a blood vessel). There were no signs that Mr Geeves had a lung lesion.
19. On 29 January, healthcare staff went to Mr Geeves' cell because he had fallen over. A nurse noted that this was the fourth time that he had fallen over within a 24-hour period. She noted that he was chesty, and his condition was deteriorating. Healthcare staff sent him to hospital, where he was given intravenous antibiotics and oxygen for pneumonia or undiagnosed chronic obstructive pulmonary disease (COPD, a lung disease). The next day, Mr Geeves had a CT scan, which showed enlarged lymph nodes in and around his lungs.
20. On 2 February, Mr Geeves had a bronchoscopy (to examine his lung tissue). On 10 February, a hospital doctor told him that he had terminal lung cancer and that he had a short prognosis.
21. On 18 February, Mr Geeves' health deteriorated, and he died in hospital later that day. His daughter was with him.

## Post-mortem report

22. A post-mortem examination established that Mr Geeves died from metastatic lung cancer (lung cancer which had spread to other parts of the body).

**Caroline Mills**  
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**August 2022**

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