

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

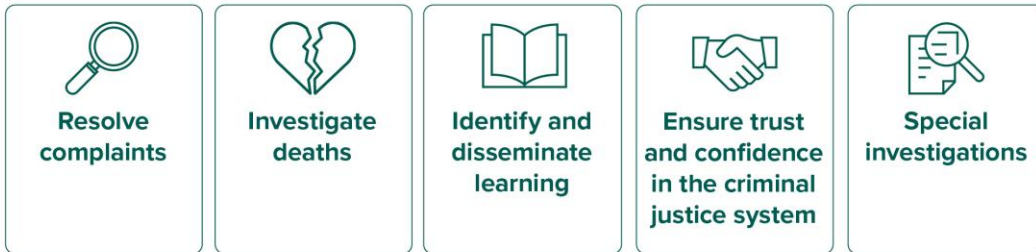
# **Independent investigation into the death of Mr Robert Revill, a prisoner at HMP Lowdham Grange, on 3 January 2022**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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 Robert Revill died in hospital of cancer on 3 January 2022, while a prisoner at HMP Lowdham Grange. He was 46 years old. I offer my condolences to Mr Revill's family and friends.

Mr Revill complained of problems with his teeth in October 2020. The prison dentist could not see him at that time due to the COVID-19 pandemic and added him to the waiting list. When the dentist saw Mr Revill in March 2021, she identified that he needed four teeth removed but she did not carry out the extractions. She removed one tooth in December when it became urgent. By then, Mr Revill was very unwell and had difficulties with breathing, eating and drinking. On 30 December, he was sent to hospital where he was diagnosed with cancer.

The clinical reviewer found that the dental care and physical healthcare that Mr Revill received at Lowdham Grange was not equivalent to that which he could have expected to receive in the community. She was concerned that the failure to remove Mr Revill's teeth in March 2021 was a missed opportunity to address his health issues and potentially could have resulted in earlier diagnosis of his cancer. She also considered that there were missed opportunities to investigate his physical health symptoms which could have led to earlier referral and treatment for his cancer.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**July 2023**

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# Summary

## Events

1. In June 2018, Mr Robert Revill was sentenced to 15 years in prison for arson. He was moved to HMP Lowdham Grange on 23 August.
2. Mr Revill first reported dental issues in October 2020. There were no face-to-face dental appointments at the time due to the COVID-19 pandemic. A prison dentist told Mr Revill that he would be added to the waiting list and seen as soon as possible.
3. On 31 March 2021, the prison dentist saw Mr Revill. She took X-rays and identified that Mr Revill needed four extractions and two fillings. She did not carry out the procedures. The dentist saw Mr Revill again on 14 June. Mr Revill said he had begun experiencing intermittent pain in his mouth.
4. In December, Mr Revill complained of swelling to the left side of his mouth in addition to the pain. The swelling continued to worsen, and Mr Revill struggled to eat and drink. On 29 December, the prison dentist removed one of Mr Revill's teeth.
5. On 30 December, Mr Revill was advised he should go to hospital due to his pain, swelling, and lack of drinking. Mr Revill insisted he did not need to go to hospital, as he had had his problematic tooth removed. A nurse assessed that Mr Revill did not have the mental capacity to refuse to go to hospital and sent him there.
6. Mr Revill was diagnosed with advanced cancer and died in hospital on 3 January 2022.
7. Hospital doctors gave the cause of death as cancer of unknown primary origin.

## Findings

8. The clinical reviewer found that the dental care and physical healthcare that Mr Revill received at Lowdham Grange was not equivalent to that which he could have expected to receive in the community.
9. The clinical reviewer was concerned that Mr Revill did not have the necessary tooth extractions on 31 March 2021. She considered that potentially his cancer may have been diagnosed earlier if his dental issues had been addressed sooner.
10. The clinical reviewer concluded that there were missed opportunities for investigating Mr Revill's symptoms, including his breathlessness and cough, which could have potentially led to an earlier referral and treatment for his cancer.
11. The clinical reviewer concluded that the entry in Mr Revill's medical records regarding his mental capacity was brief and not supported by an official assessment tool. She was also concerned that there was no evidence Mr Revill was aware he was being assessed.

## Recommendations

- The Head of Healthcare and Time for Teeth Director of Clinical Care should instigate an immediate investigation into the dental assessment and treatment of Mr Revill between 31 March and 30 December 2021.
- The Head of Healthcare should instigate an immediate investigation in the physical care and assessment Mr Revill received between 31 March and 30 December 2021.
- The Head of Healthcare and Time for Teeth Clinical Director should initiate an immediate record keeping audit and ensure that all staff, including agency and external staff using the prison SystemOne, are up to date with training in record keeping management.
- The Head of Healthcare and lead for IMHT should ensure that all healthcare staff receive training and regular updates in relation to the Mental Capacity Act and Deprivation of Liberties Safeguards (DOLs) and are clear on their accountability in assessing for mental capacity and recording their assessment in accordance with best practice guidance and codes of practice.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her.
13. The investigator obtained copies of relevant extracts from Mr Revill's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Revill's clinical care at the prison. NHS England also commissioned an NHS dental advisor. All three of them interviewed three members of Time for Teeth staff on 8 and 24 February. The investigator and NHS dental advisor interviewed two members of healthcare staff on 4 March.
15. We informed HM Coroner for Nottinghamshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Revill's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
17. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

## Background Information

### HMP Lowdham Grange

18. HMP Lowdham Grange is a Category B male adult prison located in Lowdham, Nottinghamshire, and accommodates up to 888 prisoners. The prison is operated by Serco Ltd. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare services and Time for Teeth provide dental services.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Lowdham Grange was in February 2021. Inspectors reported that the dental team had continued to work throughout the COVID-19 lockdowns, offering advice, pain relief, and antibiotics, and saw any urgent cases face to face.
20. Although the dental team reviewed its caseload to prioritise those with urgent need, the inability to provide aerosol generating procedures (procedures which can result in the release of airborne particles and increase the risk of transmission of infections such as COVID-19) since August 2020 led to excessive waiting times. A ventilation system was due to be installed to recommence this work, though the delay in ordering this further lengthened waiting times.
21. They recommended that routine GP appointments and treatment for dental patients should be provided promptly in timescales equivalent to those in the community.

### Independent Monitoring Board

22. 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 31 January 2021, the IMB reported that ventilation in the dentistry suite had long been inadequate and that the prison had installed temporary equipment until a suitable air conditioning system could be installed. The Board noted that in the past, there had been unacceptably long waiting times for dental treatment, and that it would monitor these more closely through the coming year.

### Previous deaths at HMP Lowdham Grange

23. Mr Revill was the fifth prisoner to die at Lowdham Grange since January 2020. Of the previous deaths, one was self-inflicted, one was drug-related, one was due to COVID-19, and one is awaiting classification. There are no similarities between our findings in the investigation into Mr Revill's death and our investigation findings for the previous deaths.

## Key Events

24. In November 2017, Mr Robert Revill was remanded in prison custody, charged with arson. In June 2018, he was sentenced to 15 years in prison. He was moved to HMP Lowdham Grange on 23 August.
25. On 21 October 2020, after Mr Revill raised concerns about his teeth, a prison dentist telephoned him and told him that there were currently no face-to-face dental appointments due to the COVID-19 pandemic. Mr Revill said that his wisdom teeth were sharp and he also had some broken teeth. He said he was not in any pain and had no swelling. The prison dentist told Mr Revill that he would be seen as soon as possible and added him to the waiting list. He told him that if he started to notice swelling, he should seek urgent medical attention.
26. On 31 March 2021, a prison dentist saw Mr Revill. She took X-rays and identified that four teeth needed to be extracted and two needed fillings.
27. On 14 June, a prison dentist saw Mr Revill again. He said he had begun experiencing intermittent pain. She advised further X-rays were needed, prescribed antibiotics, and referred Mr Revill to Nottingham University Hospital for the extraction of four teeth. (He was subsequently given an appointment for 3 November, but it was cancelled by the hospital.)
28. Mr Revill failed to attend a dental review with the dental therapist on 16 September.
29. On 14 December, a prison dentist held a telephone appointment with Mr Revill. He said he had pain and swelling to the left side of his mouth but did not feel unwell. The dentist prescribed more antibiotics and arranged a further telephone appointment for the following week.
30. Mr Revill had a telephone appointment with the hospital on 15 December, but he failed to attend the prison's healthcare unit to take the call.
31. On 21 December, a prison dentist tried to telephone Mr Revill but there was a problem with the line. She asked for him to be followed up the next day.
32. On 22 December, Mr Revill telephoned a dental therapist asking to be seen, but he refused to leave his cell to go to the healthcare unit. Mr Revill said that the swelling had spread into his throat and was affecting his swallowing and breathing.
33. A nurse assessed Mr Revill in his cell later that day and noted that he was coughing. She did not see any swelling on Mr Revill's face, or in his mouth or throat, and only minimal swelling on the right side of his neck. Mr Revill said he got short of breath when he moved, but that this was normal for him and he thought this was due to his chest. The nurse arranged for Mr Revill to be monitored closely and added him to the dental ledger to be seen on 29 December (there was no dental cover over the Christmas period). She told him to contact healthcare staff if he began to feel worse.
34. On 23 December, a nurse reviewed Mr Revill in his cell. She took Mr Revill's observations and sent a request to the dental team to review Mr Revill's condition.

35. Later that day, the dental therapist contacted Mr Revill, but he did not want to attend the healthcare unit. She sought advice from the Dental Clinical Lead, who prescribed more antibiotics.
36. On 24 December, a nurse reviewed Mr Revill. His observations were normal apart from a high pulse. She noted that he was taking an antibiotic.
37. On 25 December, a nurse reviewed Mr Revill. She noted that he did not have any breathing issues but had a cough which had lasted three weeks.
38. On 26 December, a nurse reviewed Mr Revill and again noted he had a cough. He also recorded that Mr Revill had shortness of breath which had lasted a few weeks.
39. On 27 December, a nurse assessed Mr Revill and noted that he was struggling to drink because of his pain. After seeking a second opinion from a second nurse, they discovered that Mr Revill had not taken his antibiotics. The second nurse encouraged Mr Revill to take his antibiotics, try a soft diet and gargle with salt water.
40. Later that day, a nurse reviewed Mr Revill again and recorded that his swelling had worsened, and he was still experiencing breathing difficulties. Mr Revill was still not taking his antibiotics. She decided to send Mr Revill to A&E due to the worsening swelling and potential kidney failure caused by him not drinking. Mr Revill discharged himself before he could be assessed or receive treatment.
41. On 29 December, a prison dentist saw Mr Revill for a face-to-face appointment. She found an abscess and removed a tooth. She stated at interview that Mr Revill said he did not wish to go ahead with the hospital appointment, and only wanted the sharp tooth removed. She described him as looking very ill and being breathless. She was concerned about his physical and mental health so spoke to the prison GP, who suggested she send a request to the mental health team.
42. On 30 December, a nurse reviewed Mr Revill who stated he had not been eating or drinking.
43. Later that day, a nurse assessed Mr Revill. She recorded that she was concerned about Mr Revill's mental capacity. She discussed this with the occupational therapist and mental health practitioner, from the mental health team, who then undertook a mental capacity assessment on Mr Revill. At interview, she said that she and the nurse thought Mr Revill should be in hospital as he did not appear to know what was wrong with him, and that he may not be lucid due to his temperature.
44. At interview, the nurse said she was concerned that Mr Revill did not appear to understand the severity of his condition and was concerned that he may begin to have kidney issues due to his lack of drinking. She advised him that he needed to go to hospital for further assessment, but he refused to go.
45. Following the occupational therapist and mental health practitioner assessment of Mr Revill's mental capacity, she concluded that he did not have the capacity to make decisions about his health at that time. Prison staff then arranged for Mr Revill to be taken to hospital.

46. Hospital staff diagnosed Mr Revill with cancer. On 2 January 2022, they told Mr Revill that treatment would not be possible due to the risk to his heart.
47. Mr Revill died in hospital on 3 January.

### **Contact with Mr Revill's family**

48. On 2 January, at around 4.00pm, the prison appointed a prison counsellor, as the family liaison officer (FLO). The FLO told Mr Revill's mother and sister that Mr Revill was in hospital and unable to have visitors due to the COVID-19 pandemic. On 3 January, at 3.25pm, the FLO informed them of Mr Revill's death by phone and offered her condolences. The prison contributed to the funeral costs in line with policy.

### **Support for prisoners and staff**

49. After Mr Revill's death, the Assistant Director 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.

### **Cause of death**

50. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Revill's cause of death as advanced carcinoma (cancer) of unknown primary origin.

## Findings

51. The clinical reviewer concluded that the dental care and physical healthcare that Mr Revill received at Lowdham Grange were not equivalent to the care he could have expected to receive in the community.
52. The clinical reviewer was concerned that Mr Revill did not have the relevant X-rays and tooth extractions when he was seen by the dentist on 31 March 2021. The dentist said she was not confident to remove the teeth. There is no evidence she sought advice from the Dental Clinical Lead. She went on to remove one of the teeth, and offered to remove another two, on 29 December when it became urgent. Not removing all the teeth in March was a missed opportunity to remove the assumed health issues which appear to have masked the head and neck cancer from being diagnosed earlier. If this had happened Mr Revill could have received more appropriate urgent referrals and treatment in accordance with cancer.
53. The clinical reviewer also considered that there were missed opportunities for investigating Mr Revill's symptoms, including his breathlessness and cough, which could have potentially led to an earlier referral and treatment for his cancer. She noted that it was impossible to say whether Mr Revill could have had curative treatment for his cancer if diagnosed sooner, but that the management/symptom control could have been different if his cancer had been diagnosed earlier.
54. The clinical reviewer considered that the entry in Mr Revill's medical records regarding his mental capacity was brief and not supported by an official assessment tool. She was also concerned that there was no evidence that Mr Revill was aware he was being assessed.
55. We make the following recommendations:

**The Head of Healthcare and Time for Teeth Director of Clinical Care should instigate an immediate investigation into the dental assessment and treatment of Mr Revill between 31 March and 30 December 2021.**

**The Head of Healthcare should instigate an immediate investigation in the physical care and assessment Mr Revill received between 31 March and 30 December 2021.**

**The Head of Healthcare and Time for Teeth Clinical Director should initiate an immediate record keeping audit and ensure that all staff, including agency and external staff using the prison SystemOne, are up to date with training in record keeping management.**

**The Head of Healthcare and lead for IMHT should ensure that all healthcare staff receive training and regular updates in relation to the Mental Capacity Act and Deprivation of Liberties Safeguards (DOLs) and are clear on their accountability in assessing for mental capacity and recording their assessment in accordance with best practice guidance and codes of practice.**

## **Inquest**

56. The inquest, held on 19 February 2024, concluded that Mr Revill died from natural causes.

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Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100