Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Chambers, a prisoner at HMP Hull, on 17 June 2024

A report by the Prisons and Probation Ombudsman

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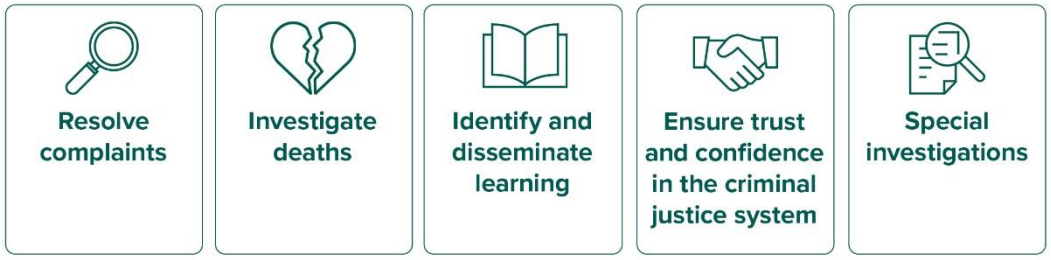
OUR VISION

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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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr John Chambers was recalled to prison in January 2021. He had previously been sentenced to life imprisonment for sexual offences and served 14 years. He died of cancer on 17 June 2024, at HMP Hull. He was 70 years old. We offer our condolences to those who knew him.

4. Mr Chambers had no nominated next of kin, so the Ombudsman's office did not contact anyone about this investigation.

5. The PPO investigator investigated the non-clinical issues relating to Mr Chambers' care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Chambers' clinical care at HMP Hull.

7. The clinical reviewer concluded that the care Mr Chambers received at Hull was variable. Some aspects of care were equivalent to that which he could have expected to receive in the community and some not. The clinical reviewer found that Mr Chambers' unexplained weight loss was not escalated to a GP to assess whether a referral to specialists was needed. The clinical reviewer made five other recommendations on issues not directly related to Mr Chambers' death, which the Head of Healthcare will wish to address. We recommend:

   The Head of Healthcare should ensure that the healthcare team adhere to NICE guideline: Suspected cancer: recognition and referral, by escalating changes in a patient's weight to the GP who can then decide on the most appropriate plan of care.

8. We shared our initial report with HMPPS and with the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies. Spectrum Community Health CIC provided an action plan which is annexed to this report.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

The inquest, held on 13 December 2024, concluded that Mr Chambers died from natural causes.

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