

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Lobb, a prisoner at HMP Oakwood, on 10 November 2023

A report by the Prisons and Probation Ombudsman

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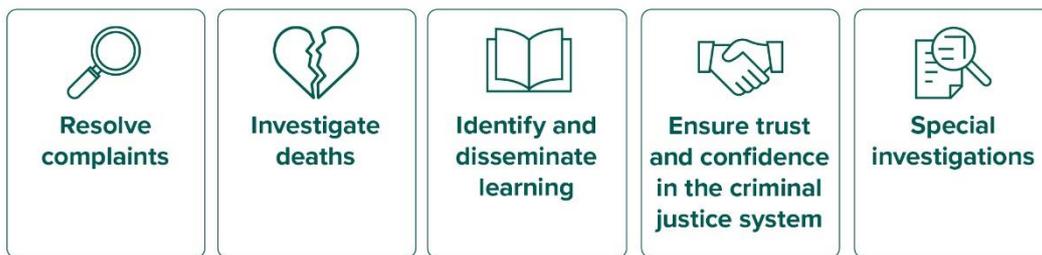
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OUR VISION

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. On 20 January 2020, Mr Terence Lobb was sentenced to four years imprisonment for sexual offences. He died in hospital of heart disease on 10 November 2023, while a prisoner at HMP Oakwood. He was 58 years old. We offer our condolences to Mr Lobb's family and friends.
4. The PPO family liaison officer wrote to Mr Lobb's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Lobb's wife asked us to investigate the healthcare Mr Lobb received at Oakwood when he became unwell. This is addressed in the clinical reviewer's report.
5. NHS England commissioned an independent clinical reviewer to review Mr Lobb's clinical care at Oakwood.
6. The clinical reviewer concluded that the clinical care Mr Lobb received at Oakwood was of a good standard overall and was largely equivalent to that which he could have expected to receive in the community. The exception was the failure to identify that he had reported similar significant symptoms on two consecutive days before he was fully reviewed. The clinical reviewer noted that since Mr Lobb's death, the Head of Healthcare had introduced a new process to ensure that prisoners who reported sick were reviewed by nurses the same day. The clinical reviewer made three recommendations which the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Lobb's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared our initial report with HMPPS and with the healthcare provider at Oakwood. They pointed out some factual inaccuracies in the clinical reviewer's report, which has been amended.
10. We sent a copy of our initial report to Mr Lobb's wife. She responded with some comments but did not identify any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

May 2024

Inquest

The inquest heard on 3 June 2024 concluded that Mr Lobb died from natural causes.



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