

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Lord, a prisoner at HMP Frankland, on 5 October 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 Steven Lord died of bronchopneumonia caused by advanced lung cancer on 5 October 2020, while a prisoner at HMP Frankland. He was 53 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Lord received at Frankland was not of the required standard and was not equivalent to that which he could have expected to receive in the community. Healthcare staff missed opportunities to identify Mr Lord's cancer and escalate his care.
5. The clinical reviewer made two recommendations, listed below. She made two further recommendations which were not directly related to Mr Lord's death, but the Head of Healthcare will need to address.
6. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that clinical staff appropriately refer prisoners with possible cancer for specialist assessment, using the suspected cancer pathway in line with NICE guidelines.
- The Head of Healthcare should ensure that staff use the National Early Warning Score (NEWS) assessment tool and follow the recommended clinical escalation procedures.

Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Lord's clinical care at Frankland.
8. The PPO investigator has investigated the non-clinical issues in Mr Lord's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. We shared the initial report with the prison service. There were no factual inaccuracies and their action plan has been appended to this report.
10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Previous deaths at HMP Frankland

11. There were 18 deaths from natural causes (five of which were related to COVID-19) at Frankland in the two years before Mr Lord's death.
12. We have previously made recommendations that healthcare staff did not appropriately refer prisoners with possible cancer for specialist assessment, in line with NICE guidelines. We have also made recommendations regarding the clinical escalation procedures when using NEWS scores

Key Events

13. On 12 March 2019, Mr Steven Lord was convicted of sexual offences and sentenced to 21 years in prison. On 29 May, he was transferred to HMP Frankland.
14. Mr Lord had a complex medical history, including heart disease. On 26 August, Mr Lord saw a prison GP, with chest pain. The doctor prescribed antibiotics for a chest infection. On 7 September, Mr Lord told the prison GP that he still had pain when breathing which was getting worse. Neither GP referred Mr Lord for urgent investigation under the suspected cancer referral pathway, which was not in line with NICE guidelines.
15. On 8 September, two nurses used the National Early Warning Score 2 (NEWS2), a tool to detect acute illness and deterioration. The score was 5, which indicated medium risk, so the nurses arranged for Mr Lord's transfer to hospital.
16. Hospital staff treated Mr Lord for suspected lung cancer and pneumonia. On 18 September, Mr Lord returned to Frankland.
17. On 25 September, a prison GP sent Mr Lord back to hospital because he had a raised calcium level in his blood and NEWS2 score of 3. On 29 September, Mr Lord went back to Frankland and remained on the prison healthcare wing.
18. On 30 September, Mr Lord's diagnosis of lung cancer was confirmed. He was seen in healthcare by a MacMillan nurse to discuss palliative care. Mr Lord agreed that if his condition deteriorated, he did not want to be resuscitated and signed an order to that effect.
19. Between 1 and 4 October, prison healthcare staff recorded Mr Lord's NEWS2 score, which moved between 5 and 10. Despite the high scores, he was not referred for urgent assessment or taken to hospital.
20. At 10.39am on 5 October, a prison GP reviewed Mr Lord and sent him to hospital because his condition had deteriorated. Mr Lord died in hospital of pneumonia as a result of lung cancer at 8.42pm that night.

Clinical Findings

21. The clinical reviewer found that the care that Mr Lord received at Frankland was not equivalent to that which he could have expected to receive in the community. The clinical reviewer said that a prison GP should have referred Mr Lord earlier for urgent investigation under the suspected cancer referral process, in line with NICE guidelines. The clinical reviewer also said that healthcare staff did not appropriately escalate Mr Lord's care when his NEWS2 scores were medium to high.

