Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Lamb, a prisoner at HMP Hull, on 27 May 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

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 Paul Lamb, who was 74 years old, died of organising pneumonia caused by lung cancer on 27 May 2022 while a prisoner at HMP Hull. We offer our condolences to Mr Lamb's family and friends.

4. The clinical reviewer concluded that the care Mr Lamb received at HMP Hull was of a variable standard and partially equivalent to that which he could have expected to receive in the community. She made several recommendations about the sharing of information, ensuring that there are standard operating procedures in place for secondary care, early days in custody and complex case management. She also made a recommendation about updating care plans and ensuring that long-term clinics are delivered in a timely way. We repeat her recommendations below.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that there is a secondary care standard operating procedure in place which ensures effective information sharing of clinical information between the prison healthcare and local secondary care trusts, to ensure timely sharing of information to support with the continuity of care.

- The Head of Healthcare should ensure that there is an Early Days in Custody standard operating procedure in place which includes the timely request of community GP records to ensure continuity of care.

- The Head of Healthcare should ensure there is a Complex Case Management standard operating procedure in place in line with appropriate national guidance.

- The Head of Healthcare should ensure that care plans are initiated and updated in appropriate timescales and are responsive to the clinical needs of the prisoner, in line with appropriate national guidance.

- The Head of Healthcare should ensure that long-term conditions clinics are delivered in line with appropriate national guidance.

Investigation Process

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

7. The PPO investigator has investigated non-clinical issues, including Mr Lamb's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The Ombudsman's family liaison officer wrote to Mr Lamb's next of kin, his partner, to explain the investigation. His partner raised the following issues:

    - following Mr Lamb's diagnosis and treatment for breast cancer, his care was lacking;
    - there was an unacceptable delay in returning Mr Lamb to his cell after being discharged from hospital;
    - Mr Lamb's cell sharing risk assessment and allocation was not appropriate;
    - there was damp in Mr Lamb's cell;
    - there was a lack of contact in respect of Mr Lamb's final admission to hospital; and
    - concerns about the actions of the staff accompanying Mr Lamb during his final admission to hospital.

9. The issues that are within the scope of our investigation have been addressed in this report and in separate correspondence.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies in the clinical review which has been amended accordingly.

Previous deaths at HMP Hull

11. Mr Lamb was the twelfth prisoner to die at Hull since May 2020. Of the previous deaths, seven were from natural causes and four were self-inflicted.

12. In a previous investigation into the death of a prisoner at Hull in June 2021, we made recommendations about the management of long-term conditions and the appropriate use of care plans. The prison accepted our recommendations and said that prisoners with long-term conditions were identified during the reception process and then referred to long-term clinics at the prison. They said that the system was reviewed on a monthly basis to ensure compliance. It is therefore disappointing that these issues are evident in this report.

Key Events

13. On 7 May 2021, Mr Paul Lamb was sentenced to seventeen years in prison for historic sex offences. He was sent to HMP Hull.

14. Mr Lamb had several pre-existing medical conditions, including chronic obstructive pulmonary disease (COPD, the term used to describe a collection of respiratory diseases) and osteoarthritis. Following his initial health screen at Hull, a nurse referred Mr Lamb to the prison's long-term clinic. There is no evidence in his medical records to suggest that the clinic offered him appointments to review his conditions.

15. The following day, healthcare staff conducted Mr Lamb's secondary health screen. They should have reviewed his community medical records as part of the secondary health screen process, but they did not ask for his community medical records until 10 May.

16. On 22 July, a prison GP saw Mr Lamb after he complained of swelling to his right nipple. He considered that Mr Lamb may have developed breast cancer and made a two week wait cancer referral to the hospital's breast clinic.

17. On 9 August, Mr Lamb was reviewed by the hospital's Breast Care Unit. They took a sample of the lump in his breast. On 31 August, Mr Lamb received his test results, which showed that he had breast cancer. As part of his treatment plan, hospital staff planned to carry out a mastectomy (a surgical procedure to remove the affected breast tissue) at a later date.

18. On 22 September, Mr Lamb underwent a mastectomy and sentinel node biopsy (used to ascertain the spread of cancer). He was discharged from hospital the following day and healthcare staff continued with his care. There is no evidence in Mr Lamb's medical records to suggest that healthcare staff devised specific care plans to manage his care.

19. On 26 October, Mr Lamb had a follow up review at the Breast Care Unit. Hospital staff were satisfied that the mammogram had been successful, and that the biopsy did not show any spread of cancer. They prescribed appropriate medication for his on-going treatment and planned to review him again in a year.

2022

20. On 4 March 2022, a prison GP saw Mr Lamb after he reported pain at the site of his mastectomy. Mr Lamb told him that he had chosen to stop taking the medication prescribed to him because he was concerned about the possible side effects. The GP explained to him the importance of taking the medication as part of his ongoing treatment and Mr Lamb agreed to start taking his medication as prescribed.

21. A prison GP saw Mr Lamb again on 27 April, after he complained of experiencing shortness of breath and fatigue. The GP prescribed him with a course of antibiotics. He also requested blood tests and a chest X-ray. Two days later, on

22. 29 April, a nurse reviewed Mr Lamb after he again complained of shortness of breath. She referred him to a prison GP for review.

23. A prison GP saw him later that day. He took a note of Mr Lamb's observations, but there is no evidence that he took a National Early Warning Score2 (NEWS2, a nationally recognised tool to facilitate the early detection of deterioration by categorising a patient's severity of illness). He considered that Mr Lamb would benefit from a review by hospital staff, and he sent Mr Lamb to hospital by emergency ambulance.

24. Mr Lamb was diagnosed with fluid on the lungs. The hospital conducted a series of tests and the results showed that the breast cancer had returned and had spread to his liver. He was admitted to hospital as an inpatient and prescribed a course of intravenous antibiotics. Mr Lamb was discharged from hospital and returned to Hull on 5 May. Despite the return of his breast cancer, there is no evidence that healthcare staff held multidisciplinary team meetings, or complex case management meetings (patients with complex healthcare needs can be logged and managed by a range of healthcare professionals, specific to the needs of the patient) to manage his care.

25. On the 9 May, a nurse saw Mr Lamb again after he complained of shortness of breath. He took a note of his observations and recorded a NEWS2 score of nine (a score of seven and above indicates a patient in urgent need of medical care). He sent Mr Lamb to hospital by emergency ambulance.

26. Mr Lamb was diagnosed with lung cancer. He was admitted to hospital as an inpatient. Hospital staff created a palliative treatment plan and completed a ReSPECT form on his behalf (Recommended Summary Plan for Emergency Care and Treatment, a plan that indicates a patient's clinical care in a future emergency in which they do not have capacity to make or express choices including cardiopulmonary resuscitation).

27. On 27 May, hospital staff told the staff accompanying Mr Lamb that he had less than 48 hours to live. His condition continued to deteriorate in hospital and, at 2.15pm, a hospital doctor confirmed that Mr Lamb had died.

Post-mortem report

28. The Coroner gave Mr Lamb's cause of death as organising pneumonia caused by disseminated carcinoma of the lung (lung cancer).

Inquest into Mr Lamb's death

29. The inquest into Mr Lamb's death was held on 11 April 2023 and a verdict of natural causes was recorded.

30. The coroner concluded Mr Lamb's death was due to organising pneumonia and disseminated carcinoma of the lung.

Lisa Burrell **July 2023**
Assistant Ombudsman

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