Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Knight, a prisoner at HMP Lowdham Grange, on 2 November 2023

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. In December 2016, Mr Alan Knight was sentenced to life imprisonment with a tariff (minimum time he would spend in prison) of 18 years for an offence of murder. He died in hospital of oesophageal cancer on 2 November 2023, while a prisoner at HMP Lowdham Grange. He was 58 years old. We offer our condolences to Mr Knight's family and friends.

4. The Ombudsman's office wrote to Mr Knight's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Knight's clinical care at Lowdham Grange.

6. The clinical reviewer concluded that the clinical care Mr Knight received at Lowdham Grange was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation which did not impact on her assessment of equivalence, that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Knight's care. We did not find any non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

9. Mr Knight's family received a copy of the draft report. They did not make any comments.

Good Practice

10. The compassion demonstrated by the family liaison officer when Mr Knight's condition deteriorated and following his death was commendable. She showed considerable empathy and her efforts went beyond what would normally be expected.

11. At an inquest held on 18 December 2023, the Coroner concluded that Mr Knight died of natural causes.

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

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