

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jacob Blow, a prisoner at HMP Exeter, on 9 May 2024

A report by the Prisons and Probation Ombudsman

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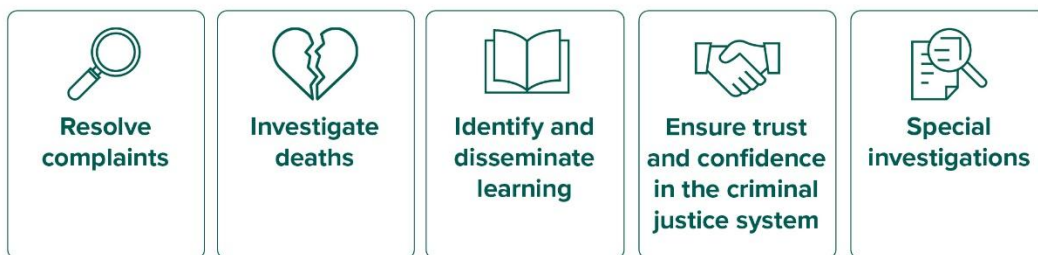
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OUR VISION

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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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. 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 Jacob Blow died in hospital of biliary sepsis, with necrotising pancreatitis, end stage renal failure, and diabetes mellitus on 9 May 2024, while a prisoner at HMP Exeter. He was 34 years old. We offer our condolences to Mr Blow's family and friends.
4. Mr Blow had regular hospital appointments for dialysis treatment both before and during his time in prison. His health and mobility slowly deteriorated, and, in the last three months, it was recognised that he was moving towards the end of his life.
5. The clinical reviewer concluded that the clinical care Mr Blow received at Exeter was equivalent to that which he could have expected to receive in the community. She made six recommendations not related to Mr Blow's death which the Head of Healthcare will wish to address.
6. There was some inconsistency in the escort risk assessments prepared before Mr Blow went to hospital for treatment. Healthcare staff sometimes objected to the use of restraints, and sometimes did not. Towards the end of his life, when he was close to death and a hospital inpatient, restraints were used without proper consideration to his poor health and mobility.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, that authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk, and that risk assessments are regularly reviewed when a prisoner remains in hospital as an inpatient.

The Investigation Process

7. We were notified of Mr Blow's death on 9 May 2024.
8. NHS England commissioned an independent clinical reviewer to review Mr Blow's clinical care at Exeter.
9. The PPO investigator investigated the non-clinical issues relating to Mr Blow's care.
10. The Ombudsman's office wrote to Mr Blow's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Exeter

12. Mr Blow was the eighth prisoner to die at Exeter since May 2021. Of the previous deaths, one was from natural causes and six were self-inflicted. To the end of September 2024, there have been two further deaths, one of which was due to natural causes. There are no similarities between the findings in our investigation into Mr Blow's death and the findings from our investigations into the previous deaths.

Key Events

13. On 6 April 2021, Mr Jacob Blow was diagnosed with renal (kidney) failure and recommended for dialysis. (Dialysis is the process of removing toxins and excess water from the blood in people whose kidneys can no longer perform this function.) Mr Blow visited a hospital renal unit where he had dialysis treatment three times a week. (The procedure usually takes around four hours.) He was also prescribed medication to support this.
14. On the 11 August 2022, Mr Blow was convicted of rape and sentenced to four years and two months in prison. He was sent to HMP Exeter. It was his first time in prison. A GP at Exeter prescribed his medication.
15. Prison staff escorted Mr Blow to hospital three times a week for his dialysis treatment. Following a risk assessment, he was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an escorting officer) throughout these hospital visits.
16. From May 2023 to November 2023, Mr Blow continued having hospital appointments for his dialysis treatment. He often declined to go to hospital for treatment. Mr Blow said that he did not like to attend three times a week because of a fear of hospitals and the impact such frequent treatment had on his mental health. Healthcare and hospital staff created a dialysis care plan that meant that Mr Blow only needed to attend twice a week.
17. Mr Blow's health slowly deteriorated, and he began to use a wheelchair some of the time.
18. Mr Blow continued to decline to attend some dialysis appointments. On 8 January 2024, prison staff recorded that although Mr Blow understood the consequences of his actions he had "given up fighting".
19. On 12 January, a nurse identified a deterioration in Mr Blow's health, and he was admitted to hospital. A prison family liaison officer (FLO) contacted Mr Blow's mother and told her that it was important he kept going to his dialysis, otherwise he could become very ill. They also discussed a do not attempt resuscitation order (DNAR) that Mr Blow had signed.
20. In February, Mr Blow continued to refuse to attend hospital appointments. Healthcare staff noted that Mr Blow was now within end-of-life care. Prison staff used suicide and self-harm prevention procedures (known as ACCT) to support Mr Blow.
21. In March, hospital staff identified that Mr Blow would benefit from having dialysis three times a week again. Mr Blow agreed to this and, other than on 27 March, now began to have thrice weekly dialysis. The FLO spoke to Mr Blow's parents to update them on his health.
22. On 29 March, healthcare staff completing the escort risk assessment objected to the use of restraints because Mr Blow used a wheelchair. Security staff assessed that Mr Blow was high risk to the public (due to the nature of his offences) and

normal risk of escape. The authorising manager concluded that he should be restrained with an escort chain.

23. On 12 April, Mr Blow was taken to hospital for a dialysis appointment. He was restrained by an escort chain and escorted by two officers. He remained in hospital for 11 days, during which time he received surgery and spent time in the Intensive Care Unit (ICU). Mr Blow was restrained with an escort chain during his time in the ICU. He returned from hospital on 23 April.
24. On 24 April, Mr Blow refused to go to hospital for dialysis. He said that he had come back from hospital recently and did not wish to go anywhere. Mr Blow also refused to collect his medication in the evening.
25. On 29 April, Mr Blow declined to attend dialysis because he wanted to go in a car rather than the minibus provided. (There were no cars available.) Mr Blow was seen by healthcare staff agreed to go to his appointments later that week. Healthcare staff continued to monitor him.
26. On 3 May, Mr Blow attended dialysis. Healthcare staff completed an escort risk assessment in which they highlighted that he used a wheelchair but did not object to the use of restraints. A prison manager authorised the use of an escort chain for Mr Blow.
27. On 6 May, Mr Blow went to hospital for dialysis. Healthcare staff objected to the use of restraints, due to Mr Blow's use of a wheelchair and dialysis treatment. He was restrained by escort chain, including during his dialysis treatment. Hospital staff found that Mr Blow's health meant that he should remain in hospital for ongoing treatment.
28. On 9 May, hospital doctors stopped all medication for Mr Blow, who was now near the end of his life with a prognosis of around seven days. Prison staff immediately started the early release on compassionate grounds (ERCG) process. All the necessary information was collected but Mr Blow died before the application could be submitted.
29. In the morning, a prison nurse contacted the duty governor to request that the restraints were removed. The duty governor authorised for Mr Blow's restraints to be removed.
30. At 5.53pm, Mr Blow died.

Liaison with Mr Blow's family

31. On 9 May, the FLO called Mr Blow's mother to tell her he was seriously ill and that death was imminent. Mr Blow's parents were with him when he died.

Cause of Death

32. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Blow's cause of death as biliary sepsis and necrotising pancreatitis, end stage renal failure, and diabetes mellitus.

Findings

Restraints, security and escorts

33. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
34. Mr Blow was 34 years old, in deteriorating health and, from late 2023, sometimes used a wheelchair. Mr Blow used a wheelchair more frequently towards the end of his life. He was ill throughout his time at Exeter and visited hospital (when he agreed to attend) two or sometimes three times a week. There were no recorded incidents of Mr Blow displaying behaviour in hospital that might indicate an increased risk to the public or of escape. Restraints were used for most of his time in hospital, but we found that, towards the end of his life, there was inconsistency and some poor decision-making in the level required.
 - On 29 March 2024, healthcare staff objected to the use of restraints. This was overruled by an authorising manager and Mr Blow was restrained with an escort chain.
 - From 12 April, Mr Blow spent nine days in hospital, including some time in an ICU. He was restrained throughout.
 - On 24 April, healthcare staff objected to restraints due to Mr Blow's reduced mobility and because he was in a wheelchair. (Mr Blow chose not to attend hospital that day.)
 - On 3 May, in a revised escort risk assessment, healthcare staff now did not object to the use of restraints, other than during dialysis treatment.
 - On 6 May, healthcare staff objected to the use of restraints. Mr Blow was handcuffed during treatment and until a few hours before he died on 9 May.
35. There were inconsistencies in the healthcare assessment of whether restraints were appropriate. In late March, healthcare staff recommended that restraints were not applied. A few weeks later, however, other healthcare staff did not identify objections.
36. In April, Mr Blow spent nine days in hospital including some time in an intensive care unit. He was restrained throughout. In May, restraints were used until only a few hours before Mr Blow died – including during treatment when healthcare staff had asked for them to be removed. When it became clear that he would remain in

hospital as an inpatient, no one reconsidered the use of restraints until this was requested by a hospital nurse.

37. We appreciate that Mr Blow was ill for some time and that he had a slow rather than sudden deterioration in his health. While it was recognised that an old-style escort chain (which is lighter and considerably more flexible than the new style escort cable) was beneficial to Mr Blow, towards the end of his life the decisions to restrain Mr Blow were not appropriate and should have been proactively reviewed when he was an inpatient and very unwell. The prison has a responsibility to balance risk of escape with treating prisoners with humanity. The presence of two escorting officers by themselves should have been sufficient to manage any risk Mr Blow might have presented during this time.
38. We frequently raise concerns about how well healthcare staff understand, or feel empowered, to make a meaningful contribution to the risk assessment process, such as in this case. In March 2024, we recommended that NHS England develop national guidance for establishments to develop local standard operating procedures for healthcare input into restraints risk assessments. This recommendation was accepted, and NHS England told us that they are working with HMPPS to review the Prevention of Escapes – External Escorts Policy Framework, with particular focus on the escort risk assessment. We also welcome the work that the Operational Security Group Director has undertaken to review and amend the national risk assessment form, mandate its use, and provide additional guidance to staff responsible for making decisions about the use of restraints.
39. In the meantime, we make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, that authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk, and that risk assessments are regularly reviewed when a prisoner remains in hospital as an inpatient.

Inquest

40. The inquest into Mr Blow's death concluded on the 4 August 2026. The coroner confirmed that Mr Blow died from natural causes.

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