Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Alan Blake, on 14 July 2024, following his release from HMP Liverpool

## 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

# 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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Alan Blake died from complications of metastatic lung carcinoma (lung cancer which has spread to other parts of the body) on 14 July 2024, following his release from HMP Liverpool on 3 July 2024. He was 56 years old. We offer our condolences to those who knew him.

5. The clinical reviewer concluded that the clinical care Mr Blake received at Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Blake. We make no recommendations.

# The Investigation Process

7. HMPPS notified us of Mr Alan Blake's death on 5 August 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Blake's clinical care at HMP Liverpool.

9. The PPO investigator investigated the non-clinical issues relating to Mr Blake's care. She obtained copies of relevant extracts from Mr Blake's prison, probation and medical records. She also interviewed two members of probation staff on 14 October.

10. We informed HM Coroner for Liverpool of the investigation. He gave us the results of the post-mortem examination. The Coroner informed us that they were not holding an inquest. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Blake's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She replied with several questions about Mr Blake's clinical care which are addressed by the clinical review. Her questions about his fitness for transferring prisons, food refusal and the support he received from probation are addressed in this report. Other questions she asked fell outside the remit of the clinical review and our investigation.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

13. Mr Blake's family received a copy of the draft report. They pointed out one factual inaccuracy and this report has been amended accordingly. Mr Blake's family also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

### HMP Liverpool

14. HMP Liverpool is a category B prison which holds convicted and remanded male prisoners.

### Probation Service

15. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Liverpool was in July 2022. Inspectors reported that resettlement work was of a good standard, but that appointments with healthcare could take too long.

# Key Events

17. On 13 July 2023, Mr Alan Blake was convicted of taking drugs and a phone into a prison. He was sentenced to 27 months in prison and taken to HMP Altcourse. On 25 July 2023, he was moved to HMP Berwyn. Mr Blake had Chronic Obstructive Pulmonary Disease (COPD – a condition caused by damage to the lungs or airways).

18. On 4 December 2023, Mr Blake told healthcare staff that he had had back pain for two weeks. On 8 December, he was taken to hospital to investigate this pain. He returned to prison on the same day. Hospital staff did a scan of his back, found a lump on his spine and decided he needed an MRI (used to create a detailed picture of a part of the body) and noted they would send him an appointment. On 13 December, a GP noticed that this appointment had not been made.

19. Mr Blake had been given codeine (a painkiller) in hospital but did not bring any with him to prison because he knew it was a medication that would not be allowed in his possession. Nurses gave Mr Blake paracetamol. The following day, the prison GP reviewed Mr Blake's records and agreed with paracetamol being adequate to manage Mr Blake's pain.

20. On 8 January 2024, officers informed healthcare staff that Mr Blake had fallen on the floor. Healthcare staff checked him and had no concerns. Mr Blake said he was 'absolutely fine'. Healthcare staff checked him during the night and again the following day.

21. On 19 January, Mr Blake did not attend a scheduled GP appointment. It was rescheduled for 6 February. On 22 January, staff told Mr Blake that he had met the criteria to be moved to an open prison. Staff noted that he seemed happy about this. However, after his death, his daughter told us that he had objected to the move to prison staff because he was in pain. There is no record of this.

22. On 29 January, a healthcare administrator sent information about Mr Blake's medical conditions to HMP Kirkham (an open prison) to ensure that they could meet his needs.

23. On 6 February, Mr Blake transferred to Kirkham. Healthcare staff noted that he was fit for prison transfer (although he was not seen face to face) and gave him pain medication for his transfer. He was seen by healthcare staff when he arrived. On 7 February, a nurse noted that Mr Blake still needed an MRI scan. In the following weeks, Mr Blake told healthcare staff that his pain was getting worse.

24. On 7 March, results of a bowel cancer screening were abnormal, so healthcare staff booked appointments for this to be investigated further. Officers asked healthcare staff to see Mr Blake as he was in pain. The GP arranged for Mr Blake to have an ultrasound scan.

25. On 12 March, Mr Blake told an officer that he had not been eating well and was struggling to collect his meals as the kitchen was too far from his cell. The officer arranged for prisoners to bring Mr Blake's food to his cell. On 14 March, a prisoner who was trying to collect Mr Blake's lunch told staff that the kitchen was not aware of this arrangement. Staff contacted kitchen staff to resolve the issue. On 18 March,

Mr Blake was allocated a buddy (a fellow prisoner who supported Mr Blake with practical support such as accompanying him to appointments or collecting his food).

26. On 21 March, hospital staff noted that Mr Blake had missed several appointments with them in relation to his abnormal bowel test results. A nurse spoke to Mr Blake who said he did not wish to have any other tests until his back pain was resolved.

27. Mr Blake continued to tell staff that he was in pain. However, he was not complying with his prescribed pain medication at times as he said they were not effective. When Mr Blake lost weight, healthcare staff put him on a weight gain diet.

28. On 29 May, staff received the results of a drug test done on 15 May. Mr Blake tested positive for cocaine, opiates, cannabis, ketamine (used by anaesthetists) and prescription medications which had not been prescribed to him. Officers found codeine in Mr Blake's cell that had not been prescribed to him and he also had excess amounts of his own medication. Mr Blake said that he had taken the drugs as a way of self-medicating because of his back pain.

29. As a result, on the same day, he was assessed as unsuitable for open conditions and transferred to HMP Liverpool (a closed prison). Healthcare staff assessed him in reception and again on 4 June. Mr Blake said he had chronic lower back pain. His observations were normal, but he was slightly underweight for which he was already prescribed nutritional supplement drinks. Staff referred him to the long-term conditions clinic for regular weight checks and sent a request to kitchen staff for Mr Blake to receive a fortified diet.

30. On 13 June, a prison GP requested urgent blood tests due to Mr Blake's continued pain and weight loss. The results of these were abnormal. Mr Blake was referred for an urgent chest X-ray in view of his weight loss and COPD history. A GP also followed up the referral for the MRI scan which had initially been made in February. They were also concerned that he might have cancer in his digestive system and the GP referred Mr Blake to the gastroenterology team under the two-week wait rule (a system where the NHS has to provide an appointment within two weeks of a request if there are concerns a patient has cancer).

31. On 18 June, Mr Blake went to hospital for a chest X-ray. On 21 June, following the results of Mr Blake's X-ray healthcare staff suspected that Mr Blake might also have lung cancer and referred him to the respiratory team under the two-week wait rule.

32. On 24 June, Mr Blake told staff his pain had increased. He was reviewed by a GP and his pain relief medication increased. On 26 June, Mr Blake moved to the inpatient unit at Liverpool. On 28 June, a GP saw Mr Blake who said he had been coughing up blood and had severe back pain which was radiating down both legs. Staff took Mr Blake to hospital where he was admitted. A family liaison officer was assigned and contacted Mr Blake's next of kin who visited him in hospital. On 1 July, hospital staff diagnosed Mr Blake with lung cancer.

33. On 3 July, Mr Blake was released from prison under the End of Custody Supervised Licence scheme (ECSL- which allowed prisoners to be released up to 70 days early from 23 May to ease overcrowding in prisons), but he remained in hospital until his death on 14 July.

## Pre-release planning

34. Mr Blake met the criteria for Home Detention Curfew (a scheme which allows some prisoners to be released early from prison, but only if they have a suitable address to go to). In December 2023, prison staff contacted Mr Blake's Community Offender Manager (COM) to assess if the address that Mr Blake proposed was suitable for him to live in. Subsequently, she assessed both Mr Blake's home address with his partner and mother's address as unsuitable due to risk issues.

35. On 22 February, the COM met Mr Blake along with his Prison Offender Manager (POM). During this meeting they discussed release plans, including where he would live, and how his health would impact him working after his release. The POM said that he had fallen while at Berwyn, that healthcare staff had found a lump on his spine, and that he was waiting for an MRI. He also said he did not need the COM's support.

36. On 27 February, Mr Blake's daughter called the COM to say that she was concerned about her father's health and that he was in significant pain. She also said she would be happy for her father to live with her so that he could be released. The COM said she would email the POM about Mr Blake's health. In their email exchange, the POM copied in the healthcare team and explained that all healthcare appointments, both in prison or the hospital, needed to be booked via prison healthcare. On 28 February, the COM emailed the healthcare department to ask for an update on the MRI and to raise Mr Blake's daughter's concerns again.

37. On 6 March, the COM told the POM that Mr Blake's daughter's address would not be suitable for him to live due to safeguarding concerns. The POM told Mr Blake, who was disappointed. Mr Blake later suggested his uncle's address for release. However, following Probation Service checks, this was also not deemed suitable. Mr Blake was then referred for accommodation support so he could get a suitable address upon release.

38. On 28 May, Mr Blake met the COM and POM. Mr Blake said he was still waiting for healthcare information, but the COM noted he was mostly focused on his frustration over his proposed release addresses being deemed unsuitable.

39. On 3 July, Mr Blake was released under the End of Custody Supervised Licence scheme. Since Mr Blake was released to hospital, the housing assessments for accommodation support did not go ahead.

## Post-release management

40. Mr Blake was released from prison on 3 July. The COM suspended all standard probation appointments because he was in hospital, but he was still subject to licence conditions, including that his address would need to be approved by probation should he be discharged. She contacted hospital staff, who confirmed Mr Blake would not be discharged soon. On 11 July, she called Mr Blake's daughter to confirm that, if Mr Blake were to be discharged on end of life care, he could stay at his home address with his partner. The address had been previously not considered suitable, but given the change in health circumstances, she considered the risk of harm was reduced.

41. The COM then went on long-term leave, so she was unable to follow up on Mr Blake's health situation. On 24 July, a Probation Service Officer called Mr Blake's daughter to check on his condition. Mr Blake's daughter told her that Mr Blake had died on 14 July.

## Post-mortem report

42. The post-mortem report concluded that Mr Blake died from complications of metastatic lung carcinoma.

# Findings

## Clinical care

43. The clinical reviewer concluded that the medical care that Mr Blake received at HMP Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer had no concerns about the physical healthcare that Mr Blake received at Liverpool. She made no recommendations. As Mr Blake died after his release, her review focused on the pre and post release planning for Mr Blake and she did not make a conclusion about equivalence of care before he moved to Liverpool.

## Weight loss

44. On 12 March, Mr Blake told prison staff that he had not been eating well and was struggling to collect his meals as the kitchen was far away. Staff ensured that a prisoner collected Mr Blake's meals for him, and he was allocated a buddy.

45. Mr Blake's daughter told us that he did not eat for 16 days. We found no record of this. Evidence suggests that, once aware of his difficulties, staff acted promptly in getting Mr Blake's meals taken to him and healthcare staff prescribed him fortified meals and nutritional supplements to try and lessen his weight loss and ensure that he was adequately nourished.

## Probation support

46. Mr Blake had two different conversations with his COM to discuss his release. The main issue they discussed was his release address. Mr Blake mentioned his health concerns during these calls, but said he was waiting to hear from healthcare staff.

47. Mr Blake's daughter shared with the COM the concerns she had about her father's health and pain. The COM raised these concerns with the POM on the same day. They both forwarded these concerns to healthcare. Both the COM and the POM acted appropriately and swiftly in forwarding these concerns to healthcare staff.

**Adrian Usher**
**Prisons and Probation Ombudsman** **March 2025**

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