

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Blows a prisoner at HMP Norwich on 25 June 2019

**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 David Blows died of bile duct cancer, cirrhosis of the liver and chronic alcoholism on 25 June 2019 at HMP Norwich. He also had Type 2 diabetes which contributed to but did not cause his death. He was 66 years old. We offer our condolences to Mr Blows' family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Blows received at Norwich was of a good standard and equivalent to that which he could have expected to receive in the community. However, she was concerned that there was no evidence that Mr Blows had had an initial health screen when he was transferred to Norwich and that he was not seen by a GP when he lost a significant amount of weight.
5. Staff did not consider Mr Blows' poor health, including his terminal cancer and deteriorating condition, and restrained him when he went to hospital.

## Recommendations

- **The Head of Healthcare should ensure that all healthcare staff are aware of and comply with guidance from the National Institute for Health and Care Excellence (NICE) on the physical health of people in prisons and healthcare reception screening (NG57).**
- **The Head of Healthcare should ensure that staff refer prisoners to a GP in a timely manner when there are significant changes in symptoms.**
- **The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Investigation Process

6. NHS England commissioned a clinical reviewer to review Mr Blows' clinical care at HMP Norwich. The clinical review is attached to this report at Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Blows' care, including his 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 Blows' brother to explain the investigation. He did not have any specific questions.
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.

### **Previous deaths at Norwich**

10. There have been seven deaths from natural causes and three self-inflicted deaths at HMP Norwich in the two years before Mr Blows' death. There are no similarities between our findings in the investigation of Mr Blows' death and the other deaths.

### **Key Events**

11. On 21 July 2016, Mr David Blows was sentenced to seven years in prison for sex offences. In October 2018, Mr Blows was diagnosed with incurable cancer within the biliary system (which consists the liver, pancreas, bile ducts and gallbladder). He was transferred to HMP Norwich on 22 January 2019 for palliative care. Mr Blows also had Type 2 diabetes, alcoholic cirrhosis of the liver, enlarged veins in the oesophagus and a hernia.
12. On 6 June 2019, Mr Blows' health deteriorated, he had difficulty swallowing, he had limited mobility and his blood test results were abnormal. Prison staff sent him to hospital, restrained and escorted by two officers. Although he received treatment in hospital, his physical condition deteriorated further and he was sent back to Norwich on 21 June for end-of-life care.
13. On 25 June, Mr Blows died in Norwich of cholangiocarcinoma (bile duct cancer), caused by alcoholic cirrhosis of the liver which in turn was caused by chronic alcoholism. He also had Type 2 diabetes which contributed to but did not cause his death.

### **Findings on non-clinical issues**

#### **Use of restraints**

14. When prisoners travel outside of prison, staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.
15. 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 he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.
16. Prison staff completed an escort risk assessment before they sent Mr Blows to hospital on 6 June 2019. His health had deteriorated, he had terminal cancer, he

had difficulty swallowing and his blood test results were abnormal. When a nurse completed the medical section, he noted that Mr Blows had impaired mobility and had a Personal Emergency Evacuation Plan (used for prisoners who needed assistance evacuating a prison in an emergency). However, the nurse did not object to the use of restraints. A Custodial Manager noted that Mr Blows posed a medium risk to the public, should be treated as a Category C prisoner and be restrained by a single cuff or 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 officer). The Head of Recruitment and Retention authorised that two officers should escort Mr Blows to hospital by taxi and that Category C restrictions should apply. Mr Blows was restrained but there is no evidence to say whether he was restrained by a single cuff or an escort chain.

17. On 8 June the Head of Segregation, Equalities, Use of Force and Violence Reduction, authorised that the restraints should be removed. Mr Blows was not restrained for the remainder of his stay in hospital.
18. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. The nurse had access to Mr Blows' medical records and should therefore have known about his health and medical conditions. There is no evidence to justify why there was no objection to the use of restraints given Mr Blows' terminal cancer, limited mobility and deteriorating condition. Mr Blows was transferred to Norwich to receive end-of-life care, he lived in a wing for elderly prisoners and these factors were not taken into consideration when the risk assessment was completed. Mr Blows was restrained in hospital for two days before the restraint was removed. This was just two weeks before he died. 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 and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

## **Annexes**

1. Clinical review

### **Additional documents**

2. Prison action plan

