Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Blackburn, a prisoner at HMP Altcourse, on 2 June 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141

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 Michael Blackburn died in a hospice on 2 June 2021 from throat cancer, while a prisoner at HMP Altcourse. Mr Blackburn was 81 years old. We offer our condolences to Mr Blackburn's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Blackburn received at Altcourse was partially equivalent to that he could have expected to receive in the community. She found that while certain aspects of his care were good, including his end-of-life care, there were several shortcomings, including in the initiation of care plans, the use of clinical risk assessment tools and in following NICE guidelines in cases of suspected cancers.

5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that staff initiate nursing care plans and risk assessments in a timely manner.

- The Head of Healthcare should investigate the missed opportunities of a referral via the suspected cancer pathway following Mr Blackburn complaining of difficulty in swallowing and identify the learning points.

The Investigation Process

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

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

8. The PPO family liaison officer wrote to Mr Blackburn's next of kin, his daughter, to explain the investigation. She did not have any specific questions for us to consider but asked for a copy of our report.

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

10. We sent a copy of our initial report to Mr Blackburn's daughter. She pointed out some factual inaccuracies which we have amended in this report.

Previous deaths at HMP Altcourse

11. Mr Blackburn was the 15th prisoner to die at Altcourse since June 2019. Of the previous deaths, 11 were from natural causes, two were self-inflicted, and one was from unknown causes. There were no significant similarities between our findings from our investigation into Mr Blackburn's death and our findings from the previous deaths.

Key Events

12. On 14 November 2019, Mr Michael Blackburn was sentenced to five years imprisonment for sexual offences, and sent to HMP Altcourse.

13. Mr Blackburn had ischemic heart disease (caused by narrowed arteries), hypertension (high blood pressure), and atrial fibrillation (abnormal heart rhythm). He was provided with care for angina (chest pain caused by not enough blood going to the heart), cervical spondylosis (age related wear and tear to the spinal disks), benign paroxysmal positional vertigo (a common cause of vertigo, causing episodes of dizziness), and dyspepsia (indigestion). Due to these multiple and complex health needs, healthcare staff saw him frequently to monitor these conditions.

2020

14. On 22 January 2020, a prison nurse found Mr Blackburn had a reddened spine. To enable daily monitoring of this, Mr Blackburn was transferred to the prison healthcare unit.

15. On 13 May, the prison GP reviewed Mr Blackburn due to a reduction in his haemoglobin levels (the protein molecule in red blood cells that carries oxygen to the body's tissues), and complaints of rectal bleeding. The GP referred Mr Blackburn to hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

16. On 16 June, hospital investigations found Mr Blackburn had haemorrhoids. The follow-up plan was for Mr Blackburn to attend a routine gastroenterology clinic (a branch of medicine focused on the digestive system) on 25 February. The gastroenterologist advised Mr Blackburn was not fit for treatment due to frailty and poor health.

17. Mr Blackburn continued to deteriorate, becoming frailer, experiencing periods of confusion, and struggling to swallow solid foods. The prison GP requested he was swapped to a semi-solid diet and ordered testing for urine infections.

18. The GP did not follow the NHS pathway for suspected cancer at this time, as Mr Blackburn had already been seen recently by a gastroenterologist. Instead, the GP made an urgent referral to a speech and language therapist on 31 July.

19. On 1 August, the GP reviewed Mr Blackburn four times between 1 and 17 August due to his difficulty swallowing. The GP decided to wait until Mr Blackburn's next routine gastroenterology appointment and speech and language review. Mr Blackburn was not re-referred to hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

20. On 17 August, a prison GP referred Mr Blackburn to the Ear, Nose and Throat (ENT) department at Aintree University Hospital due to his difficulty swallowing.

21. On 22 September, an ENT consultant informed Mr Blackburn he had probable throat cancer. Mr Blackburn said he did not wish to have any investigations to confirm this diagnosis or treatment, due to his frailty. He was discharged to the palliative care team.

22. Healthcare staff monitored Mr Blackburn several times a day to ensure his care needs were being met.

2021

23. On 19 January 2021, Mr Blackburn went to hospital following a fall. He was discharged back to Altcourse on 21 January. Mr Blackburn again went to hospital on 25 February as he was displaying stroke symptoms. He was discharged back to Altcourse on 9 March.

24. On 30 March, a palliative care consultant advised that Mr Blackburn move to a hospice. He moved to a hospice on 31 March.

25. Mr Blackburn died at the hospice on 2 June.

Post-mortem report

26. An inquest was held on 14 June. The Coroner concluded that Mr Blackburn died of metastatic oesophageal neoplasm (throat cancer).

Louise Richards
Assistant Ombudsman **February 2022**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141