Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Blackwell, a prisoner at HMP Oakwood, on 18 January 2025

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. 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 Stephen Blackwell died in hospital of lung cancer on 18 January 2025, while a prisoner at HMP Oakwood. He was 46 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Blackwell received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community. She made five recommendations relating to the wider care Mr Blackwell received which the Head of Healthcare will wish to address.

5. Due to concerns about his risk of falling and being unable to reach his emergency cell bell if he needed help, Mr Blackwell was issued with a personal alarm. However, records suggest that officers could not always hear it and had asked him not to use it. The prison needs to ensure that prisoners issued with personal alarms are located where they can be heard by staff and that staff have clear guidance on how to respond to personal alarms.

Recommendations

- The Governor should carry out a review to:
    - Establish whether personal alarms can be clearly heard by wing staff throughout the day and night, or whether proximity of the cell to the wing office should be considered when issuing one.
    - Develop guidance on what is expected of wing staff when responding to personal alarms; and
    - Embed a robust quality assurance process to ensure that personal alarms are being responded to promptly.

The Investigation Process

6. HMPPS notified us of Mr Blackwell's death on 19 January 2025.

7. NHS England commissioned an independent clinical reviewer to review Mr Blackwell's clinical care at HMP Oakwood.

8. The PPO investigator investigated the non-clinical issues relating to Mr Blackwell's care. She interviewed one member of staff from Oakwood on 9 May 2025.

9. The Ombudsman's office wrote to Mr Blackwell's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. HMPPS pointed out a factual inaccuracy which has been amended in this report. HMPPS provided an action plan which is annexed to this report.

Previous deaths at HMP Oakwood

11. Mr Blackwell was the nineteenth prisoner to die at Oakwood since January 2022. Of the previous deaths, 17 were from natural causes and one is still awaiting classification. There are no similarities between the findings in our investigation into Mr Blackwell's death and the findings from our investigations into the previous deaths.

Key Events

12. On 16 August 2024, Mr Stephen Blackwell was sentenced to 11 years in prison for sexual offences. He was moved to HMP Oakwood on 17 September.

13. On 1 October, Mr Blackwell went to the healthcare hub complaining of tingling in his left arm. A healthcare assistant radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff to attend and the control room to call an ambulance). A paramedic at Oakwood responded and took Mr Blackwell's clinical observations, which were all within normal range. She cancelled the ambulance and scheduled a blood test for the next day. Mr Blackwell said he had experienced this symptom before at his last prison, but it had not been assessed.

14. On 2 October, Mr Blackwell had a blood test, which was abnormal. On 7 October, a GP reviewed the results and was concerned about a high level of CRP (C-reactive protein, a test for inflammation in the body). He advised to repeat the test in one week. If the results were still abnormal, the GP would arrange an appointment with Mr Blackwell.

15. On 15 October, an officer asked healthcare staff to check on Mr Blackwell as he had weakness in his left arm. A nurse took his clinical observations and calculated a NEWS2 score of zero. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk. A score of zero is low risk.) She asked for another blood test to be done the same day, the results of which were abnormal.

16. On 18 October, a GP reviewed the blood test results and noted that the CRP level was still high. The GP requested a follow up. On 21 October, a GP reviewed the same set of blood test results and asked for the test to be repeated in two to three weeks.

17. On 26 October, an officer radioed a code blue as Mr Blackwell had spasms in his left arm. A paramedic at Oakwood responded and assessed him in his cell. She took his clinical observations, which were all within normal range, and found no weakness in his left arm at the time. She cancelled the ambulance and requested a GP appointment.

18. On 29 October, while at education, Mr Blackwell had spasms in his arm. A nurse assessed him, took his clinical observations, and calculated a NEWS2 score of zero. She noted that there was no weakness in his left arm and recorded that he was awaiting a GP appointment for this ongoing issue.

19. Later that day, Mr Blackwell went to the medical kiosk and told staff that he had lost the use of his arm, was struggling to breathe, and kept collapsing. Healthcare staff did not assess him again that day.

20. On 1 November, a GP examined Mr Blackwell to check how well his brain, spinal cord and nerves were working. Mr Blackwell said he had collapsed at education that morning, and a few days ago. He was unable to use his left arm and complained of pressure in his head. The GP referred him to A&E for further assessment.

21. On 2 November, while at hospital, Mr Blackwell had a CT scan which showed multiple growths on his brain, which could be tumours.

22. On the morning of 3 November, Mr Blackwell discharged himself from hospital against medical advice, which meant he did not have more tests on his brain.

23. Later that evening, Mr Blackwell's cellmate found him collapsed on the floor and called for help. A nurse took his clinical observations, which were normal, and found he was conscious and alert. Mr Blackwell told her that he had pressure in his head, so she advised he went back to hospital. An ambulance was called, and paramedics took him to A&E.

24. On 4 November, Mr Blackwell had a further CT scan, which showed he had cancer that had spread to his brain. Doctors told him that further tests were needed to find the source of the cancer.

25. On 13 November, Mr Blackwell had a CT tap (where a CT scan is used to guide a doctor, taking a small amount of fluid from the spinal cord to check for infections or other conditions). The results suggested he had lung cancer, but the doctors were unsure if this started in the lung or if it had spread from another part of the body.

26. On 15 November, a lung specialist told Mr Blackwell that his cancer was terminal, and he would be started on palliative care.

27. On 18 November, a nurse at Oakwood referred Mr Blackwell to the palliative in-reach care team for support with managing his symptoms when he returned from hospital. On 20 November, Mr Blackwell was discharged and returned to Oakwood.

28. On 22 November, Mr Blackwell was allocated a wing carer to help him with daily activities including making his bed and cleaning his cell. Mr Blackwell struggled to do these tasks independently due to weakness in his arm and poor balance.

29. On 26 November, a nurse assessed Mr Blackwell in his cell. He told her that he had a terminal diagnosis but was going to have any available treatment to prolong his life.

30. On 27 November, a nurse at Oakwood completed a falls assessment for Mr Blackwell. She referred him to Occupational Therapy (OT, helps people improve their ability to perform everyday activities) to see if there were any supportive measures that could be put in place to help him with his balance. She also undertook a clinical risk assessment on the use of restraints on Mr Blackwell for his visits to hospital and recommended that he should not be handcuffed due to his diagnosis and frailty in his left arm and leg.

31. On 3 December, a nurse at Oakwood was told by the palliative care team that Mr Blackwell's prognosis was six months to a year, and he would be told this at his next hospital appointment. The nurse asked the hospital to provide a report confirming his prognosis so they could start an Early Release on Compassionate Grounds (ERCG) application.

32. On 6 December, an oncologist (cancer doctor) diagnosed Mr Blackwell with lung cancer that had spread to other parts of his body. He told him that his prognosis was between six months to a year. Mr Blackwell was handcuffed for his hospital

appointment. This was due to a member of healthcare staff accessing the wrong record. She acknowledged that in future she must check the prisoner number rather than searching just by surname. Mr Blackwell was not handcuffed again after this.

33. On 17 December, following a social care assessment, prison staff gave Mr Blackwell a personal wrist alarm so he could alert officers if he had fallen or needed urgent help. (A personal alarm emits a loud sound when pressed, which continues until it is switched off by pressing a button on the alarm.) However, Mr Blackwell refused to wear it as it was dirty. A nurse asked for a replacement alarm to be issued, which was given to him the next day. Mr Blackwell was still awaiting a formal prognosis from the hospital for his ERCG application.

34. On 2 January 2025, Mr Blackwell told a palliative care nurse that he did not want to proceed with his application for ERCG until after he had completed immunotherapy treatment (where the immune system is used to treat cancer). Due to his anxiety, prison staff paused his application and continued to speak to him about his concerns.

35. On 7 January, at around 8.15pm, Mr Blackwell pressed his personal alarm. When an officer responded, Mr Blackwell said he was having chest pains, and the officer radioed a code blue. A nurse arrived and found Mr Blackwell alert, sitting on his bed. Mr Blackwell said that he had had a bad convulsion before pressing his alarm and he thought he was having a stroke. The nurse took his clinical observations and checked for any signs of weakness that would indicate a stroke. The nurse assessed that Mr Blackwell appeared stable, but did not cancel the ambulance as they wanted the paramedics to assess him. When the ambulance arrived, paramedics did an electrocardiogram (ECG, a test to check the rhythm and electrical activity of the heart) and took further clinical observations, which were all normal. The paramedics advised that Mr Blackwell did not need to go to hospital, but healthcare staff should contact them again if his symptoms worsened.

36. On 15 January, Mr Blackwell told a nurse at Oakwood that he was worried that if he was released, his treatment would not continue to the same standard. The nurse reassured him that this would not affect his treatment. However, he said he still did not want to continue with the ERCG application at this time. She agreed to continue to speak with him about this.

Events on 16 January

37. On 16 January at 10.31pm, Mr Blackwell pressed his emergency cell bell. An officer attended his cell within two minutes. Mr Blackwell told him that he was in pain.

38. Later that evening, Mr Blackwell pressed his personal wrist alarm. A prisoner in a neighbouring cell pressed his emergency cell bell at 10.46pm to alert officers to Mr Blackwell's alarm. An officer responded at 10.47pm. The officer then visited Mr Blackwell's cell and advised him to use his cell bell for any further assistance, as he would not be able to hear the personal alarm. Mr Blackwell did not press his cell bell again that evening.

39. On 17 January, at around 4.30am, an officer carried out a roll count (a check to confirm prisoners are in their cells). The officer did not report any issues.

40. At around 7.45am, an officer unlocked the cells on Mr Blackwell's wing. Officers are supposed to get a positive response from each occupant during unlock to ensure they are alive and well. During an internal investigation, the officer said that she had tried to get a response from Mr Blackwell and she heard a grunt. She did not open the door fully and so did not get a visual sighting of him. The investigation concluded that the officer had not properly checked on Mr Blackwell and a formal warning was issued.

41. At around 7.50am, a prisoner alerted an officer as they found Mr Blackwell on the floor of his cell. Mr Blackwell told the officer that he had tried to get out of bed and slipped at approximately 4.00am. When the officer asked why he had not pressed his wrist alarm, Mr Blackwell said that he had been 'told off' for pressing it the night before. A nurse took his clinical observations and calculated a NEWS2 score of 1 (which is low risk) and found no signs of injury. She arranged for social care staff to help clean up Mr Blackwell and make him more comfortable.

42. At 3.25pm, a nurse and social worker reviewed Mr Blackwell to see whether he needed more support in place. Mr Blackwell's carer was in his cell and told the nurse that Mr Blackwell had not got out of bed since the morning and had not eaten. Mr Blackwell had pain in his legs and was unable to stand. The nurse took his clinical observations and calculated a NEWS2 score of 12 (which indicates a very high risk) and radioed a code blue as she suspected Mr Blackwell had sepsis (a life-threatening condition where the body's response to an infection damages its own tissues and organs). An ambulance arrived and paramedics took Mr Blackwell to hospital for further treatment.

43. At hospital, Mr Blackwell continued to deteriorate overnight and despite treatment, he died on 18 January.

Cause of death

44. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as severe pneumonia (an infection in the lungs), caused by metastatic lung cancer (cancer which has spread to other parts of the body).

45. At the inquest, held on 31 July 2025, the Coroner concluded that Mr Blackwell died from natural causes.

Findings

Clinical findings

46. The clinical reviewer concluded that the care Mr Blackwell received at Oakwood was of a good standard overall and was equivalent to that which he could have expected to receive in the community.

47. While the clinical reviewer made some recommendations, mainly about healthcare systems and potential training needs, she did not find any elements of healthcare delivery that would have impacted negatively on Mr Blackwell or his cause of death.

48. We do not repeat the clinical reviewer's recommendations here, but the Head of Healthcare will wish to address them.

Use of personal alarms

49. All cells are equipped with an emergency cell bell which prisoners should press if they require urgent help. When a cell bell is pressed, an alarm is sounded in the wing office and a display shows which cell has activated their cell bell. A light is also activated outside the cell. The cell bell is switched off by a member of staff going to the cell and deactivating the bell by switching it off outside the cell. Staff are expected to respond within five minutes. Cell bell use is recorded to show the time cell bells are activated and deactivated by staff.

50. Prisoners at risk of falls or who may not be able to easily access their emergency cell bell, may be issued with a personal alarm, as Mr Blackwell was. Personal alarms emit a loud sound from the device itself. There is no notification in the office of a personal alarm being activated and no record of when personal alarms are activated or deactivated. A response relies on a member of staff on the wing hearing the personal alarm, or a prisoner in a nearby cell pressing their cell bell to alert staff.

51. There were evidently problems with officers being able to hear Mr Blackwell's personal alarm. On the evening of 16 January, a neighbour pressed his emergency cell bell to alert staff that Mr Blackwell had activated his personal alarm. When an officer responded, he told Mr Blackwell not to use his personal alarm as he would not hear it and to use his cell bell instead. This defeats the whole point of a personal alarm which is issued to those who may not be able to access the cell bell, either because they have fallen or have poor mobility within the cell.

52. The next morning, Mr Blackwell was found on the floor of his cell. He told the officer that he had not pressed his personal alarm as he had been 'told off' during the night for pressing it.

53. The investigator interviewed the Head of Safety at Oakwood, who has oversight of the use of personal alarms. She said that staff were expected to respond within five minutes, in line with expected response times for cell bells, though she said there was no written policy. It was her understanding that personal alarms could be heard in the wing office and she was unaware of the issues raised in this case. She said

she would investigate to establish if it was a widespread issue. (We have not been able to confirm if she has yet carried out the review.)

54. The Head of Safety told the investigator that currently, there is no consideration of where prisoners who have personal alarms are located, in relation to the wing office. She also told the investigator that currently there is no written policy on how officers should respond to personal alarms, specific training provided, or quality assurance process. She agreed that this was something she would address.

55. We recommend:

- **The Governor should carry out a review to:**
  - **Establish whether personal alarms can be clearly heard by wing staff throughout the day and night, or whether proximity of the cell to the wing office should be considered when issuing one.**
  - **Develop guidance on what is expected of wing staff when responding to personal alarms; and**
  - **Embed a robust quality assurance process to ensure that personal alarms are being responded to promptly.**

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