Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Olly Black, a prisoner at HMP Stafford, on 22 November 2021

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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 Olly Black died in hospital of a thoracic aortic aneurysm rupture on 22 November 2021, while a prisoner at HMP Stafford. Mr Black was 72 years old. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care Mr Black received at Stafford was of a good standard and equivalent to that he could have expected to receive in the community. She made one recommendation about ensuring that information from a prisoner's electronic medical record (SystmOne) is made available to paramedics when a prisoner is taken to hospital.

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

Recommendation

- The Head of Healthcare should ensure that staff know how to generate a quick glance record summary from the SystmOne records, which should be made available to paramedics when prisoners are taken to hospital.

The Investigation Process

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

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

8. Despite the efforts of the prison's family liaison officer, no next of kin for Mr Black could be identified.

9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP Stafford

10. Mr Black was the 14th prisoner to die at HMP Stafford since November 2019. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Black's death and our investigation findings from the previous deaths.

Key Events

11. In May 2016, Mr Olly Black (then known as Walter Damari) was sentenced to 18 years in prison for sexual offences. He was moved to HMP Stafford on 2 May 2018.

12. Mr Black had several long-term health conditions including a thoracic aortic aneurysm (a bulge in the aorta (the main artery in the body)), atherosclerotic disease (blocking and hardening of arteries caused by plaque), poorly controlled hypertension (high blood pressure), osteoarthritis, kidney disease and fibromyalgia (chronic muscle pain).

13. Mr Black had annual chest scans to assess his aortic aneurysm. In January 2020, he was told it had grown very slightly. He was advised to have a follow up scan in a year.

14. On 12 February 2021, Mr Black attended hospital for a CT scan of his chest. There was no change in his aortic aneurysm.

15. On 17 February, Mr Black was diagnosed with congestive cardiac failure (heart failure).

16. On 16 November, Mr Black tested positive for COVID-19. (He had received his first and second dose of the AstraZeneca COVID-19 vaccine in February and May respectively.) He was isolated in his cell. Healthcare staff monitored him daily. This included a welfare check and taking physical observations.

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17. On 18 November, at around 10.00am, a nurse saw Mr Black for a welfare check. He recorded no concerns.

18. A nurse saw Mr Black again at around 2.15pm. He found Mr Black had a swelling on the left side of his face. The nurse took Mr Black's clinical observations and calculated a NEWS-2 score of zero, which indicated no concerns. (NEWS-2 (National Early Warning Score) is a tool to measure clinical deterioration in adult patients.) The nurse advised Mr Black to drink plenty of fluids, to keep taking his medication and to press his emergency cell bell if he felt worse or found it difficult to breathe.

19. Sometime after 5.30pm, healthcare staff noted that Mr Black had not collected his evening medication from the dispensary. He was due to collect his medication at the end of the evening to avoid interaction with other prisoners.

20. A nurse went to Mr Black's cell. He found that Mr Black was wheezing when breathing and the swelling on his face had doubled in size. The nurse gave Mr Black oxygen and called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

21. Mr Black was taken to hospital by emergency ambulance. Two prison officers accompanied him, but no restraints were used in line with his health condition and assessed level of risk.

22. Mr Black was admitted to hospital and treated for parotitis (inflammation of the parotid glands situated in either side of the mouth).

22 November 2021

23. On 22 November, doctors assessed Mr Black was well enough to be discharged back to the prison and had prescribed him medication. At around 2.40pm, Mr Black was on the hospital ward with escorting officers waiting for a discharge letter.

24. Mr Black drew the curtain around his bed to change from his hospital clothes into his own. Prison officers heard Mr Black make a strange coughing noise and then go silent. Officers drew back the curtain and found him slumped on his bed, unresponsive and not breathing.

25. Officers immediately pulled the emergency cord and shouted for assistance. The hospital 'crash' team attended and spent 25 minutes trying to resuscitate Mr Black. However, despite their intervention, Mr Black did not respond to treatment. He was pronounced dead by a hospital doctor at 3.15pm.

Cause of death

26. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Black's cause of death as a thoracic aortic aneurysm rupture (the bursting of a bulge in the aorta) caused by hypertension. The doctor noted that Mr Black had congestive cardiac failure (heart failure) which did not cause but contributed to his death.

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