

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Colin Black, on 11 September 2023, following his release from HMP Bullingdon**

**A report by the Prisons and Probation Ombudsman**

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## **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**



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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. Since 6 September 2021, the PPO has been investigating 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 Colin Black died of multiple injuries sustained when he was hit by a car on 11 September 2023, following his release from HMP Bullingdon on 5 September. Toxicology tests following his death identified illicit substances and alcohol in his blood. He was 30 years old. We offer our condolences to those who knew him.
5. Mr Black had a history of substance misuse. He continued using illicit substances in prison, while at the same time engaging with the substance misuse team, who warned him about the risks and dangers of taking drugs. Prison and probation staff arranged a substance misuse appointment in the community following his release, but Mr Black did not attend.
6. We make no recommendations.

## The Investigation Process

7. We were notified of Mr Black's death on 14 September 2023.
8. The PPO investigator obtained copies of relevant extracts from Mr Black's prison and probation records.
9. We informed HM Coroner for Reading of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
10. The Ombudsman's office contacted Mr Black's mother to explain the investigation process and asked if she had any matters she wanted us to consider. Her daughter confirmed that she had no questions but asked for a copy of the report to go to her mother.
11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Bullingdon

12. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire, Berkshire, Buckinghamshire and Wiltshire. Practice Plus Group provides healthcare services and Cotswold Medicare Ltd provides GP services.

### Probation Service

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

## Key Events

14. On 21 November 2022, Mr Colin Black was convicted of fraud and motor vehicle offences and sentenced to 40 weeks in prison. He was transferred to HMP Bristol. Mr Black had a history of illicit drug use and tested positive for cocaine and buprenorphine (opiate substitute medication) on arrival, which he said he was not prescribed.
15. On 20 December, Mr Black was transferred to HMP Portland. At Portland, he worked with the prison's substance misuse service.
16. On 6 April 2023, Mr Black was released from Portland on licence.
17. On 21 April, probation staff revoked Mr Black's licence for poor behaviour and for not attending appointments with probation and other agencies as directed. Initially this was a 28-day recall, but it was changed to a standard recall (to serve the remainder of his original sentence) when they received information about further burglary charges. Mr Black remained at large in the community.
18. On 2 May, Mr Black was arrested and admitted to HMP Bullingdon. On arrival, he tested positive for opiates and cocaine and began a methadone detoxification programme. (Methadone is an opiate substitute medication.) Mr Black said he had a history of heroin, crack cocaine and methadone misuse.
19. Mr Black told staff that he was diagnosed with anxiety, for which he was prescribed mirtazapine. He also had learning difficulties and could not read or write. Mr Black had previously self-disclosed that he experienced post-traumatic stress disorder, but this diagnosis was not confirmed.
20. On 9 May, Mr Black met the prison resettlement team to complete an action plan for his release. Mr Black's licence conditions included working with a worker from Newbury Housing Department on accommodation needs. He was referred to Westminster Drug Project (WDP) to attend key working sessions and group work as deemed necessary. Mr Black would also be monitored by the Crisis Intervention Team for a referral if there were any issues. Probation staff added further requirements to the licence conditions which included Mr Black having regular drug tests. (They noted that any positive drug tests would be an indication that his risk of further offending would increase.)
21. On 19 May, probation staff called Mr Black's prison offender manager (POM). She confirmed that Mr Black was engaging and working with the prison's substance misuse service.
22. On 3 June, prison staff searched Mr Black's cell and found unauthorised items such as smoking paraphernalia and a vape cap with an unknown substance inside. (Mr Black shared the cell with another prisoner.)
23. On 23 June, a community offender manager (COM) was assigned to manage Mr Black in the community.
24. On 10 July, Mr Black met prison staff for his pre-release review. They discussed accommodation and that Mr Black did not currently have release accommodation.

25. On 19 July, staff from the Homelessness Prevention Taskforce (Southampton Council) completed a Duty to Refer application to the local authority for Mr Black. They said he was at risk of homelessness and was high risk due to a history of substance misuse.
26. On 27 July, Mr Black met his COM by video link and discussed his release plans, including accommodation options. On the same day, she spoke to a rough sleeper prevention officer to discuss Mr Black's options.
27. On 31 July, Mr Black told prison staff that he had spoken with housing and probation staff the previous week. He was hopeful they had found him somewhere to live and was waiting for more information. Mr Black said he was focusing on his release but was struggling as he had no money after losing his prison job due to suspicions he was dealing drugs.
28. On 3 August, Mr Black told prison staff that he was in debt and under threat due to owing for vape capsules.
29. On 4 August, prison staff carried out a routine search of Mr Black's cell and found a small bottle of fermented liquid.
30. On 8 August, probation staff confirmed to prison staff that Newbury Council had referred Mr Black to the Rough Sleepers Accommodation Program (RSAP - Government funded project aimed to provide accommodation to reduce rough sleeping). Mr Black had been accepted onto the scheme and would be offered accommodation on release. At that time, it was likely Mr Black would be placed in an address in Newbury, but this was to be confirmed.
31. On 16 August, staff searched Mr Black's cell and found white crystals in a small bottle. (Neither Mr Black nor his cell mate admitted ownership of the bottle. It is not recorded whether the find was referred to the substance misuse service, with whom he was already working.)
32. On 21 August, Mr Black agreed to be picked up by the Integrated Offender Management Team (IOM - brings a cross-agency response to the crime and reoffending threats faced by local communities) on release and taken to the probation office for his first appointment.
33. On 29 August, prison staff referred Mr Black to Westminster Drug and Alcohol Services (WDP) in the community.
34. Prior to his release, Drug and Alcohol Services (DAS), West Berkshire, wrote to Mr Black for an assessment appointment on 13 September, and a prescribing appointment on 7 September. (The letter was undated and probation staff could not confirm when it was sent.)
35. On 31 August, Mr Black had a pre-release review with prison staff where they discussed a number of issues, including housing. Mr Black confirmed that he had release accommodation. (This was hotel accommodation provided by his local council.)
36. On 5 September, Mr Black was released from prison on a post sentence supervision order. He was released with mirtazapine, and a naloxone pack (used to

reverse the effects of opiate overdose), and healthcare staff arranged for his methadone prescription to continue in the community.

### **Post-release**

37. As previously agreed, IOM staff collected Mr Black and took him to the probation office for a post-release appointment. At the appointment, probation staff discussed matters around Mr Black's release, including his licence conditions.
38. Mr Black did not stay at the release accommodation provided and instead went to a family member's address.
39. On 7 September, Mr Black did not attend his initial substance misuse appointment. It is unclear whether he collected methadone following his release (although methadone was detected in the toxicology examination at levels within the therapeutic range).
40. On 11 September, Mr Black called his COM and asked when he was next to report to the probation office. She told him it was 15 September. Mr Black said he was now living at the hotel provided by the council, and that he was okay. He said that he had spoken to staff and was waiting for a date to move into a room in a shared house.

### **Circumstances of Mr Black's death**

41. Later, on 11 September, Mr Black fell down an embankment on the A339 in Newbury and was fatally hit by a car.

### **Post-mortem report**

42. The post-mortem report concluded that Mr Black died of multiple injuries as the result of a road traffic collision. Toxicology tests identified that Mr Black had consumed alcohol at around twice the legal limit for driving a motor vehicle. He had also used cocaine and morphine in the time before his death. Mirtazapine and methadone were present at therapeutic levels.

### **Contact with Mr Black's family**

43. The police contacted Mr Black's family. Sadly, they already knew of his death as it had been reported on social media.



## Findings

44. Mr Black's cause of death was multiple injuries as the result of a road traffic collision when he fell in front of a vehicle. The toxicology report found he had taken alcohol, and illicit substances shortly before his death, which included cocaine and methadone. There was nothing to indicate that his death was anything other than accidental.
45. Mr Black had a history of using illicit substances, including Class A drugs. While in prison he was seen regularly by the substance misuse team and was prescribed a methadone detoxification programme (with a continuing prescription in the community on release). We are satisfied that probation staff put appropriate measures in place to address Mr Black's substance misuse in the community. This included additional licence conditions to comply with any requirements relating to addressing Mr Black's substance misuse issues. They also arranged an appointment with community substance misuse services for two days after Mr Black's release, which he chose not to attend. Healthcare staff at Bullingdon appropriately provided Mr Black with naloxone before his release.
46. We consider that prison staff and Mr Black's COM appropriately prepared him for release. They liaised with external support agencies, provided Mr Black's POM with up-to-date information before his release and arranged emergency accommodation through the local authority. However, Mr Black failed to meet the conditions, including staying at a relative's address instead of the hotel accommodation provided by Newbury Council. We are satisfied that prison and probation staff did all they could to assist Mr Black in the transition from prison to the community.

## Inquest

47. The inquest into Mr Black's death concluded on the 29 September 2025. The coroner confirmed that Mr Black died from a road traffic collision.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**October 2025**

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Third Floor, 10 South Colonnade  
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