

**INVESTIGATION INTO THE CIRCUMSTANCES  
SURROUNDING THE DEATH  
OF A MAN AT HMP BIRMINGHAM IN JULY 2005**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**October 2007**

This is a report into the circumstances surrounding the death of a man at HMP Birmingham on 25 July 2005. He was just 32 years old when he died, apparently from natural causes.

The man who died had been remanded into HMP Birmingham on 26 March 2005, four months before his death. He had received a three year custodial sentence in June 2005.

On reception, he was noted to be a substance misuser and was receiving support from the local drug service providers. He later applied for a transfer to the therapeutic community at HMP Channings Wood to address his offending behaviour.

He appeared to have an unremarkable time at Birmingham. Whilst he had a diagnosable mental health need, it was well controlled with the medication he was receiving. The clinical review, commissioned as part of my investigation, identified two learning opportunities. However, I am aware that these have been considered locally and do not propose to repeat them here.

The man was found to be unrousable on the morning of 25 July and, despite the best efforts of staff, resuscitation was not possible. The post mortem following his death was inconclusive. Low levels of heroin and prescribed medication were found in his blood, but these were not thought to have contributed to his death. The inquest into the man's death was held in May 2006 and recorded a verdict of natural causes.

I very much regret the very late completion of this report. My office's handling of this case had been unacceptable, and has shown disrespect to his family, the Coroner and the staff at HMP Birmingham. I offer an unqualified apology to all concerned.

In light of the failings on the part of my office, I ordered an urgent review of our systems and procedures. This has resulted in changes in both policy and practice that I hope will prevent any recurrence.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**October 2007**

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## **SUMMARY**

The man who is the subject of this report died unexpectedly on 25 July 2005. He was just 32 years old.

The man had been received into HMP Birmingham just four months before he died. He was subsequently sentenced to three years in prison for robbery. He had been in prison before.

On reception, he was identified as schizophrenic and as a substance misuser. He was prescribed appropriate medication to manage both conditions. The records indicate that he was responding well to both courses of treatment and that his schizophrenia was well controlled.

The man appears to have had an uneventful few months in Birmingham. He was receiving support from the local drug services and had applied to join the therapeutic community at Channings Wood.

On 25 July 2005, he was found to be unconscious when staff went to wake him to go to work. Staff immediately commenced resuscitation. Sadly, this was unsuccessful and he was pronounced dead.

An autopsy was carried out following his death. The initial findings were unable to determine the cause of death. Eventually, in February 2006 my office was informed that toxicology indicated that the man had a small amount of heroin in his system, indicating he was likely to have used some within 48 hours of his death. Other prescribed medications were found in his system, but were noted to be within therapeutic limits. The pathologist concluded the levels of drugs found would not have had any direct bearing on his death, and recorded the cause of death as unascertained - probably acute viral pneumonia.

## **METHODOLOGY**

1. The investigation was begun in July 2005 by one of my investigators, who handed over the investigation to my Deputy Ombudsman to conclude. My Deputy has completed this report using the limited information available.
2. Notices to staff and prisoners, terms of reference and the Governor's notification letter were sent for distribution and display around the prison. They announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express. No staff or prisoners came forward.
3. A clinical review was commissioned from Heart of Birmingham Primary Care Trust. The Associate Dean at the West Midlands Postgraduate Medical and Dental Deanery, undertook the review on their behalf. I am grateful for his contribution,
4. My investigator contacted the man's family at the start of the investigative process. They have not brought any concerns or issues to the attention of my office.
5. Management oversight and communication failures meant that this investigation unacceptably slipped through the net. I offer an unreserved apology for the shabby way in which the man's family, the Birmingham Coroner, and the staff at HMP Birmingham have been treated as a result. I also wrote personally to the man's father in June 2006.
6. The Coroner concluded the inquest into the man's death in May 2006. A verdict of natural causes was recorded.

## **HMP BIRMINGHAM**

7. HMP Birmingham is a local prison for adult male prisoners. It serves the Crown and Magistrates' Courts of Birmingham, Stafford and Wolverhampton and several Magistrates' Courts in the surrounding areas. The Prison Service's website records that the prison has recently undergone a period of considerable change as a result of a multi-million pound investment programme. Some 450 additional prisoner places have been provided, together with new workshops, educational facilities, a new healthcare centre and gymnasium, as well as extensions and improvements to existing facilities. HMP Birmingham now holds 1,450 prisoners.
8. The provision of healthcare within the prison is the commissioning responsibility of the Heart of Birmingham Primary Care Trust. Primary care clinics are delivered by GPs and visiting consultants. The healthcare centre has the opportunity to draw upon the broader expertise and range of healthcare services at the local City Hospital. The primary healthcare team comprises doctors, nurses and healthcare assistants. There is an in patient facility which is staffed by registered mental health nurses and a healthcare assistant during the day, and a nurse and healthcare assistant at night. They provide care for patients with primary mental health needs and those with primary physical health needs requiring 24 hour nursing care.
9. The prison was last inspected by HM Chief Inspector of Prisons, Ms Anne Owers, in May 2004. Her unannounced inspection found that Birmingham had improved in all four key areas that the Inspectorate assesses: safety, respect, purposeful activity and resettlement. However, some areas for development were identified, particularly the relationships between staff working in different parts of the prison. For example, work between healthcare and wing staff needed to be better coordinated.

## KEY FINDINGS

10. The man was received into custody in late March 2005, charged with robbery. He received a three year custodial sentence in mid June. His conditional release date would have been in mid September 2006, with a sentence expiry date of 23 March 2008.
11. On reception into custody, he was seen for a healthcare assessment. He said that he had no physical health concerns. However, he did tell the healthcare worker that he had been diagnosed as schizophrenic. This had resulted in him spending a period of time in a psychiatric hospital. He had then been prescribed Amitriptyline and Zopiclone to manage his condition in the community. These medications were continued when he arrived at HMP Birmingham.
12. He also admitted to a drug habit. His main drug of choice was heroin, but he also used crack cocaine. He said he spent £1,400 per week on drugs and used crime to fund his habit. He was referred to the substance misuse team for assessment and management, and consented to a Subutex detoxification. He commenced his detox on 29 March 2005 and completed it 12 days later.
13. The man was also referred to and seen by the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team. An initial assessment was completed. A care plan assessment was also conducted, in which he identified his wish to change his life style and address his addictive and offending behaviour.
14. Following sentence, he applied to join the Therapeutic Community at HMP Channings Wood. On 13 July 2005, he received a letter informing him that he had been successful with this application. He was hoping to transfer to Channings Wood at the end of July.
15. Whilst in prison, the man appeared settled and had gained employment on the wing servery. There are no significant entries in his history sheet and nothing in the wing observation books. All of this indicates that he was compliant with the routines and had not come to the attention of staff.
16. At about 8.45am on Monday 25 July, an officer went to his cell to collect him and his cellmate to go to work on the servery. They were due to take the trolleys back to the kitchen. When the officer arrived at the cell, the man's cellmate was sitting on his bed watching television. The officer went to wake him up and realised there was a problem. The officer then checked him and, realising that he was not breathing, summoned additional support including healthcare staff.
17. On arrival, the healthcare staff commenced cardio pulmonary resuscitation (CPR). Paramedics were called and arrived at about 9.05am. Staff continued to administer CPR with the paramedics until 9.29am. A clinical decision was taken to stop resuscitation at this point. The man's death was verified by the duty doctor.

18. Following the man's death, contact was made with his next of kin. Some members of the family were able to visit the prison and spent some time with the chaplaincy. The governor offered financial assistance towards the cost of the funeral.
19. The initial post mortem examination was unable to provide a conclusive cause of death. Samples were sent for toxicology. These later provided evidence that the man had a low level of heroin in his system, indicating he was likely to have used within 48 hours of his death. That said, the pathologist concluded this was not a factor in his death, nor were the other prescribed medications found in his blood. These were noted to be within therapeutic limits.
20. The pathologist therefore concluded that the cause of death was "unascertained – probably viral pneumonia".

## **CLINICAL REVIEW**

21. The clinical review was carried out by the Associate Dean at the West Midlands Postgraduate Medical and Dental Deanery. His review records that the man was a known schizophrenic and substance misuser. He says that, whilst in prison, the man received appropriate opiate substitution therapy to manage his withdrawal from illicit drugs. Records indicate that he tolerated this well.
22. Whilst no psychiatric opinion was sought, the clinical reviewer says the records indicate that the man received appropriate medication for his schizophrenia. Those records suggest that his condition was stable and well controlled.
23. At the time of completing his review, the clinical reviewer made two recommendations. One concerned the availability of equipment in the event of an emergency, and the other was regarding the computerisation of medical records. I am aware that both of these matters have been addressed in the interim, and therefore do not propose to repeat them in this report.

## **RECOMMENDATIONS**

24. I make no recommendations in respect of the death of the man who is the subject of this report.