Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Collins, a prisoner at HMP Birmingham, on 27 December 2024

A report by the Prisons and Probation Ombudsman

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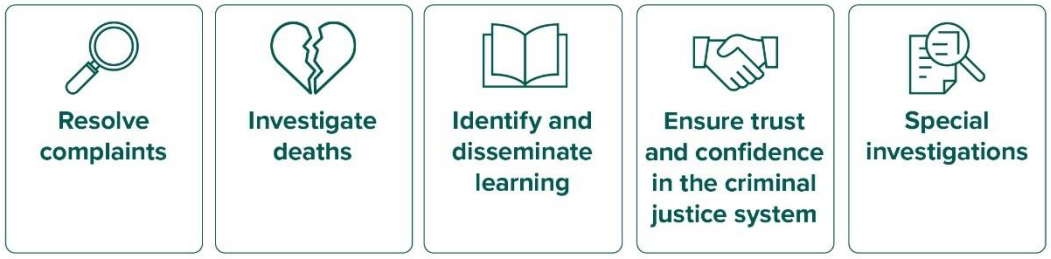
OUR VISION

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

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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. 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 Dean Collins died in hospital from multiple organ failure on 27 December 2024, while a prisoner at HMP Birmingham. This was caused by hepatic cirrhosis which was in turn caused by a hepatitis B and hepatitis C infection. He was 46 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Collins received at Birmingham was not of the required standard and was not equivalent to that which he could have expected to receive in the community. She found that there was a missed opportunity for Mr Collins to have received more timely treatment and his admission to hospital was delayed by approximately 24 hours. The clinical reviewer made a recommendation about this. She also made three other recommendations which were not relevant to Mr Collins' death but which the Head of Healthcare will want to address.

5. We found that the officer who completed the escort risk assessment did not seek input from healthcare staff when applying restraints to Mr Collins. Although Mr Collins was admitted to hospital on 21 December, escort staff did not open a bedwatch log until two days later.

Recommendations

- The Head of Healthcare should review processes for enabling urgent same day GP or other senior clinician appointments to ensure review of unwell patients in a timely fashion.

- The Governor should review how effective previous work to educate managers about the risk assessment process and the Graham judgement has been and provide additional measures, including additional training, where necessary.

The Investigation Process

6. HMPPS notified us of Mr Collins' death on 28 December 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Collins' clinical care at HMP Birmingham.

8. The PPO investigator investigated the non-clinical issues relating to Mr Collins' care. She interviewed one member of staff from Birmingham on 11 February 2025.

9. The Ombudsman's office wrote to Mr Collins' next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He asked the following questions which have been addressed in this report or in the clinical review:

   - Did Mr Collins report to prison staff that he was ill or seek help? If so, was it followed up? If not, why not?
   - Leading up to his death, had Mr Collins been ill in his cell? Was his ill health simply not picked up?
   - Mr Collins looked visibly unwell (he had a swollen body and discoloured/yellow skin). How did staff not pick up these signs/physical changes?
   - What was the delay in notifying Mr Collins' next of kin that he had been admitted to hospital? Mr Collins' family was not told until the day after he was admitted to hospital.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). Birmingham and Solihull Mental Health NHS Foundation Trust pointed out a factual inaccuracy, and this report has been amended accordingly. The action plan has been annexed to this report.

11. Mr Collins' family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Birmingham

12. Mr Collins was the fifteenth prisoner to die at HMP Birmingham since 27 December 2021. Of the previous deaths, seven were from natural causes and four were self-inflicted, one is awaiting classification, one was drug-related, and one was a homicide.

13. Birmingham accepted our recommendation in 2022 that escort staff should understand the legal position on the use of restraints and that decisions should be based on the prisoner's health and the risk presented at the time. Birmingham told us that their risk assessment had a medical section, and the Duty Governor used this information for the overall assessment. They said that members of staff who failed to consider the prisoner's risk and health at the time and do not evidence a defensible decision were subject to an internal investigation.

Key Events

14. On 10 December 2024, Mr Dean Collins was sentenced to one month in prison for contempt of court. He was admitted to HMP Birmingham and Nurse A completed his initial health screen in reception. Mr Collins reported that he had alcohol problems and a history of cocaine and heroin use. Nurse A referred him to the Birmingham Recovery Team due to substance misuse. Mr Collins' medical records indicate that he had difficulty walking and used a walking aid.

15. On 11 December, the substance misuse service saw Mr Collins and he disclosed that he had recently used drugs. Staff monitored him daily for five days and agreed that he should undertake methadone and alcohol detoxification.

16. On 16 December, Nurse B saw Mr Collins and completed an alcohol withdrawal assessment. The nurse noted that Mr Collins presented as settled and raised concerns about his sleeping pattern. He was prescribed a short-term sleeping aid. Ms A, a member of the substance misuse team, saw Mr Collins and he reported that he wanted to remain abstinent from substances in custody.

17. On 19 December, Ms A saw Mr Collins on the wing. She noted that he appeared yellow and did not look well. She sent a task to primary care for him to be reviewed.

18. On 20 December, Nurse C was called to see Mr Collins on the wing as he felt unwell. She recorded that he was alert and orientated. He reported feeling lethargic and he looked pale. Ms A spoke to Dr A, a GP operating at Birmingham, and told him that Mr Collins had become jaundiced. Dr A recorded that Mr Collins needed an urgent blood test.

19. On 21 December, a code blue was called due to Mr Collins' presentation. Nurse D attended to monitor him. On arrival, Mr Collins was lying on the bed, was not making much sense and was jaundiced. His cellmate told her that Mr Collins had been vomiting all night. Healthcare staff recorded that Mr Collins was due to have a blood test that day but due to his decline in presentation, they sent him to hospital. The ambulance left the prison at 10.45am.

20. Custodial Manager (CM) A completed an emergency escort risk assessment and decided that Mr Collins should be restrained with double cuffs (where the prisoner's hands are handcuffed together and a second pair of handcuffs are applied, attaching the prisoner to a prison officer). The healthcare section of the risk assessment was not completed. CM A told us that this was to ensure the escort left in a timely manner. He told us he had no information about Mr Collins' condition, and the decision to restrain him was based solely on the security assessment.

21. At 5.15pm, Mr Collins' restraints were changed from double cuffs to an escort chain (a long cable attached at one end to the prisoner and at the other to a prison officer) when he was admitted to hospital.

22. At 2.58pm on 22 December, Nurse E received a phone call from the hospital, asking for Mr Collins' medical history. They told her that Mr Collins was intubated and had been moved to the Intensive Care Unit. Medical records indicate that Mr Collins' restraints were removed.

23. At 5.30pm, Mr A, the prison's family liaison officer, contacted Mr Collins' brother to tell him that Mr Collins was in hospital and to explain his current condition. Birmingham told us that they contacted Mr Collins' brother when the situation became critical and that Mr A first had to complete the relevant checks and obtain the contact details for Mr Collins' brother.

24. On 23 December, Nurse F contacted the hospital. They told her that Mr Collins was in a critical but stable condition. They said that they had had a discussion with Mr Collins' brother the previous day and they had agreed to put in place an order not to attempt cardiopulmonary resuscitation if his heart or breathing stopped. They confirmed he had liver failure. The bedwatch log was opened and it was noted that Mr Collins was not restrained.

25. On 24 December, Mr A recorded that Mr Collins was in a serious condition and his family were by his bedside.

26. On 26 December, Nurse E contacted the hospital. They told her that Mr Collins remained ventilated and sedated.

27. On 27 December, Nurse E contacted the hospital. They said that they were going to withdraw treatment as Mr Collins was not improving and this had been discussed with his family. Hospital staff pronounced life extinct at 5.42pm. His family were with him when he died.

Post-mortem report

28. The post-mortem report concluded that Mr Collins died from multiple organ failure. This was caused by hepatic cirrhosis which was in turn caused by a hepatitis B and hepatitis C infection.

29. An inquest into Mr Collins' death was held on 5 August 2025. The Coroner concluded that Mr Collins died from natural causes.

Findings

Clinical findings

30. The clinical reviewer concluded that the care that Mr Collins received was not of the required standard and was not equivalent to that which he could have expected to receive in the community.

31. The clinical reviewer found that a GP or other senior clinician should have reviewed Mr Collins on the afternoon of 20 December when there were concerns that he was jaundiced. She concluded that his condition warranted further urgent medical assessment and his admission to hospital was delayed by approximately 24 hours. She therefore made the following recommendation which we repeat:

    The Head of Healthcare should review processes for enabling urgent same day GP or other senior clinician appointments to ensure review of unwell patients in a timely fashion.

Use of restraints

32. The Prison Service has a duty to protect the public when escorting prisoners outside prison such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility. A judgment in the High Court in 2007 (the Graham judgment) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

33. An escort risk assessment must be completed for every hospital escort and healthcare staff must always be involved in this process.

34. CM A completed the emergency risk assessment on 21 December 2024. He told us that the medical section of the risk assessment was not completed to ensure the escort left the prison in a timely manner. He said that as a result, he had no details about Mr Collins' medical condition and restrained him with double cuffs based solely on a security assessment (which included that Mr Collins was on remand and had a recorded history of violence, including threatening violence towards another prisoner on 18 December). However, CM A said that if he had been aware of Mr Collins' condition at the time, this would likely have resulted in a different cuffing arrangement, if any at all.

35. We have previously raised concerns about the inappropriate use of restraints at Birmingham. The Operational Security Group Director for HMPPS, Mr B, told us that, following earlier PPO recommendations, his team had reviewed a sample of risk assessments from Birmingham and identified issues which had led to targeted work at the prison to educate staff. A broader piece of work to review the national

risk assessment process had led to changes to the policy, which is likely to be published before the end of 2025.

36. Mr C, the Head of Safety, told us that the manager completing the emergency risk assessment should speak to healthcare staff or paramedics and use this information to complete the medical section. Mr C said that he expected the person completing the risk assessment to obtain further information if they did not have sufficient information to make a defensible decision.

37. Mr C told us that he encouraged managers to consider the Graham judgment when making decisions about restraints and to take a prisoner's mobility into consideration, as well as any security risks. He told us that Birmingham have conducted multiple briefings about the Graham judgment and all senior managers were aware of it.

38. Although Mr Collins was admitted to hospital on 21 December, the bedwatch log (a detailed account of events completed by staff accompanying the prisoner in hospital) was not opened until 23 December. The medical records indicate that restraints were removed on 22 December, and it is clear from the bedwatch logs that Mr Collins was not restrained on 23 December. However, due to the lack of earlier records, we have been unable to determine exactly when Mr Collins' restraints were removed.

39. As CM A had no information about Mr Collins' medical condition, he was unable to make an informed decision about whether restraints should have been used. A bedwatch log should have also been opened on 21 December. In light of this and that we have made a previous recommendation to Birmingham about this issue, we make the following recommendation:

The Governor should review how effective previous work to educate managers about the risk assessment process and the Graham judgement has been and provide additional measures, including additional training, where necessary.

Family liaison

40. The Prison Safety Policy Framework states that prisoners who have a serious or terminal illness must be encouraged to engage with their families or a nominated person where it is appropriate to do so. If the prisoner is unable to communicate their wishes, the prison should contact the next of kin or a nominated person and give them an accurate account of what has happened, including treatment given, whether the prisoner is in hospital and information about visiting the prisoner.

41. Mr Collins' next of kin was concerned that he was not informed of Mr Collins' condition until the day after he had been admitted to hospital. While we recognise their concerns and distress, the prison acted reasonably and in line with policy when contacting Mr Collins' next of kin once it was clear that he was seriously unwell.

Adrian Usher
Prisons and Probation Ombudsman **December 2025**

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