Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hicks, on 16 June 2024 following his release from HMP Birmingham

A report by the Prison 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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Peter Hicks died of lower respiratory tract infection with chronic obstructive pulmonary disease and ischaemic heart disease on 16 June 2024, following his release from HMP Birmingham on 12 June 2024. He was 63 years old. We offer our condolences to those who knew him.

5. Mr Hicks had a number of health conditions when he entered prison. He declined to engage with healthcare professionals and other services that were offered to him during his time at Birmingham.

6. Mr Hicks had a history of non-compliance and an unwillingness to engage in the pre-release planning process while in prison and in the community. As a result, it was difficult for prison and probation staff to give Mr Hicks the support he needed. However, he was appropriately referred to services in the community for additional support.

7. We did not find any significant issues for learning in the pre- or post-release planning. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Hicks' death on 3 July 2024.

9. The PPO investigator obtained copies of relevant extracts from Mr Hicks' prison and probation records.

10. We informed HM Coroner for Birmingham and Solihull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. The Ombudsman's office contacted Mr Hicks' family to explain the investigation and to ask if they had any matters, they wanted us to consider. They wanted a copy of our report.

Background Information

HMP Birmingham

12. HMP Birmingham is a reception prison housing adult man, both convicted and on remand. It is managed by HMPPS. Healthcare services are provided by Birmingham and Solihull Mental Health NHS foundation Trust.

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 supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Birmingham was in August 2018. Inspectors reported that they were concerned about some aspects of release planning which were overly complicated and disjointed. Inspectors found that the offender management unit was under-resourced, meaning that some high-risk prisoners had not been assessed early enough or with sufficient attention to make sure that their transition to the community was as safe as possible.

Key Events

Background

15. On 7 January 2024, Mr Peter Hicks was sentenced to 20 weeks imprisonment for common assault. He was sent to HMP Birmingham. On 5 March, Mr Hicks was also sentenced to six weeks imprisonment for public indecency.

16. On 25 March, Mr Hicks was released from prison on a conditional licence.

17. On 2 April, Mr Hicks was recalled to Birmingham for breaching his licence conditions. He was due to be released again on 11 April.

18. Mr Hicks' suffered from back pain, and had a history of arthritis in his knees, ankles and shoulder.

19. A nurse completed Mr Hicks' initial health screen. Mr Hicks refused to fully engage and answered 'no' to all questions. The nurse found it difficult to assess him objectively. Mr Hicks declined to confirm any information about his medical and substance misuse history. He had mobility issues and used crutches. Mr Hick's was housed on the healthcare wing.

20. On 3 April, the substance misuse team saw Mr Hicks to complete his initial screening. He declined to participate and said that he had no issues with alcohol or drugs. They advised him about psychoactive substances, and the risks and effects should they be used and that if he required the service later, he could self-refer.

21. On 9 April, Mr Hicks did not attend the pre-release group session to prepare for his release. Staff recorded that Mr Hicks said that he was too tired.

22. Accommodation was secured for Mr Hicks on release, but this was later deemed unsuitable due to his mobility issues.

23. On 11 April, Mr Hicks was released from Birmingham on a conditional release licence.

24. On 4 June, Mr Hicks was recalled to Birmingham again for breaching his licence conditions as he refused to report to the probation office. He was due to be released on 12 June.

25. Mr Hicks was taken to the healthcare unit due to his mobility and health issues. He refused to engage and was agitated. Mr Hicks had some medications with him including furosemide (for high blood pressure), thiamine and vitamin B1 (normally prescribed to those who have problematic alcohol use), warfarin (a blood thinner), paracetamol and enoxaparin (to prevent blood clots).

Pre-release planning

26. On 10 June, Mr Hicks' allocated Community Offender Manager (COM) emailed staff at Birmingham and asked the healthcare team for support in arranging transport for Mr Hicks' release on 12 June, and to put in place a healthcare support plan.

Healthcare staff referred Mr Hicks to the specialist assessment and care management services for further support in the community. Prison staff arranged his transportation.

27. The COM also emailed the adult social care team at Birmingham City Council for support in securing housing for Mr Hicks. Birmingham Council responded and advised that she should refer Mr Hicks to the Birmingham Homeless team.

28. On 11 June, Mr Hicks did not attend the pre-release group in preparation for his release. He did not give a reason for his unwillingness to attend.

Release from HMP Birmingham

29. On 12 June, Mr Hicks was released from Birmingham. His post-sentence supervision conditions were explained to him, and he signed the licence to confirm he understood. Mr Hicks took his medications with him.

30. Mr Hicks was released homeless.

31. Mr Hicks reported to the probation office for his initial appointment with his COM. Due to being homeless, she sent him to the Newtown homeless team in a taxi so that he could secure appropriate accommodation.

32. On 13 June, the COM emailed the Newtown homeless team to confirm whether Mr Hicks had attended their office, if accommodation had been secured and if they could provide the address details. She did not receive a response.

33. The next day, the COM sent a follow up email to the homeless team. They responded and said that Mr Hicks did not turn up to their office.

34. Mr Hicks was scheduled to have a planned telephone appointment with his COM so that he could provide her with his new address details. He failed to make contact with the probation office and his whereabouts were unknown.

35. Due to Mr Hicks' failure to contact the probation office, the COM submitted Mr Hicks' post sentence supervision to court for non-compliance.

Circumstances of Mr Hicks' death

36. At 3:59pm on 16 June, the police were patrolling a shopping centre in Birmingham, and found Mr Hicks in distress. The police called the Ambulance Service, and he was taken to hospital and admitted at 7:36pm.

37. That evening, Mr Hicks became unresponsive and had a cardiac arrest. Resuscitation attempts were unsuccessful, and Mr Hicks was confirmed dead at 11:45pm.

Post-mortem report

38. The post-mortem report concluded that Mr Hicks died from lower respiratory tract infection with chronic obstructive pulmonary disease and ischaemic heart disease.

Findings

39. Mr Hicks had a history of non-compliance and unwillingness to engage with professionals while in prison and in the community. Whenever he had scheduled pre-release group meetings, he did not attend. Prison, healthcare and probation staff tried to ensure that Mr Hicks received the support that he was entitled to prior to his release. Suitable accommodation had not been secured for Mr Hicks before his release, but prison and probation staff ensured that they provided transport for him to go to the Newtown homeless team and the COM followed up the referral promptly. We are satisfied that both the prison and probation services did all they could to support Mr Hicks.

40. We make no recommendations.

Inquest

41. There was no inquest into Mr Hicks' death. The coroner concluded that Mr Hicks died from natural causes.

42. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

43. Mr Hicks' family received a copy of the initial report. They did not make any comments.

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

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