Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Lomas, a prisoner at HMP Birmingham, on 2 May 2025

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

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 Brian Lomas died in hospital of pneumonia on 2 May 2025, while a prisoner at HMP Birmingham. He was 77 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Lomas received at Birmingham was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She found that he received comprehensive and compassionate nursing care. However, she had some concerns about the wider care Mr Lomas received and made eight recommendations which the Head of Healthcare will wish to address.

5. Mr Lomas was not handcuffed when he was taken to hospital on the evening of 28 April. However, the next morning, a prison manager asked one of the bedwatch officers to apply an escort chain (a long cable attached at one end to the prisoner and at the other to a prison officer) to Mr Lomas due to his risk of wandering. While the escort chain was removed two days later before Mr Lomas died, we consider it should never have been applied. Mr Lomas was an elderly man with poor mobility and breathing difficulties, and it is difficult to imagine how he could have escaped from the two officers with him.

Recommendations

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

The Investigation Process

6. HMPPS notified us of Mr Lomas' death on 2 May 2025.

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

8. The PPO investigator investigated the non-clinical issues relating to Mr Lomas' care. She interviewed two members of staff from Birmingham.

9. The Ombudsman's office wrote to Mr Lomas' son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Birmingham and Solihull Mental Health NHS Foundation Trust. HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Birmingham

11. Mr Lomas was the eighteenth prisoner to die at Birmingham since May 2022. Of the previous deaths, 11 were from natural causes, one was self-inflicted, one was a homicide and four were drug related.

12. In December 2023, we made a recommendation to the Operational Security Group Director of HMPPS to monitor compliance with policy on the use of restraints on prisoners taken to hospital. They told us that Birmingham and several other prisons would submit copies of all escort risk assessments for hospital escorts and bedwatches to the Security Procedures Team so that the level of compliance could be assessed. Also, a security briefing note was issued to security teams to remind them of the importance of balancing risk-based security requirements with individual prisoner needs on hospital escorts and bedwatches, particularly with regard to cuffing arrangements.

Key Events

13. On 2 February 2024, Mr Brian Lomas was sentenced to 11 years in prison for sexual offences. He was sent to HMP Birmingham.

14. In October 2023, prior to being sentenced, a psychiatrist diagnosed Mr Lomas with mild dementia.

15. In March 2024, an occupational therapist (OT) saw Mr Lomas in his cell after nurses raised concerns about his mobility. Mr Lomas was using a walking stick and needed help to stand and sit. The OT assessed him as being at risk of falls and gave him a walking frame, which enabled him to stand without assistance.

16. In May, a social worker assessed Mr Lomas, who was struggling with daily activities due to dementia and poor mobility. The social worker arranged a care package of three daily visits from carers.

17. Throughout Mr Lomas' time at Birmingham, staff recorded that he was forgetful and confused. In June 2024, Mr Lomas' dementia appeared to progress, and his symptoms worsened.

18. On 7 October, the healthcare team at Birmingham completed a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form, which said Mr Lomas was not to be resuscitated in the event of a cardiac arrest, as it would not be in his best interests.

19. On 5 March 2025, a GP prescribed Mr Lomas risperidone, an antipsychotic medication, to help settle his sleep pattern and mood. The healthcare team also arranged for a clock to be put up in Mr Lomas' cell to help him stay aware of the time.

20. On 27 March, Mr Lomas fell twice in his cell. Nurses assessed him for injuries and took his clinical observations but did not calculate a NEWS2 score. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk.) Nurses suspected a urine infection was causing the falls but were unable to get a urine sample. A nurse referred Mr Lomas to the GP, who prescribed antibiotics but did not see him.

21. On 3 April, a healthcare worker went to Mr Lomas' cell to give him his medication and found him sitting on the floor by his bed. Because of his dementia, she was not able to tell if he had fallen. She checked him for any injuries, took his clinical observations, and calculated a NEWS2 score of zero (indicating low risk). She found no signs of injury.

22. On 25 April, a nurse visited Mr Lomas in his cell to give him his morning medication. She was concerned that he was coughing and could only take one tablet at a time due to difficulty swallowing. She took his clinical observations and calculated a NEWS2 score of zero. She booked him a follow up appointment with a GP for that day.

23. Later that day, a GP saw Mr Lomas in his cell. They were concerned that his coughing might be caused by increased saliva, a known side effect of risperidone. The GP reduced his dose to every other evening and referred him for a speech and language therapy assessment to check his swallowing.

24. On 26 April, a nurse went to Mr Lomas' cell to weigh him and found him sitting on the toilet, having soiled himself. She was concerned that the carers who had just visited Mr Lomas had left him in this state, as they told her he they cleaned him and helped him back to bed. The nurse recorded the incident in Mr Lomas' medical notes and handed it over to the night nurse.

25. On 28 April, at around 5.20pm, a nurse found Mr Lomas coughing after his evening medication. She took his clinical observations, which showed low blood oxygen levels, and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts the control room to call an ambulance). The nurse gave Mr Lomas oxygen while waiting for the ambulance. At around 6.35pm, the ambulance arrived and took Mr Lomas to hospital, where he was admitted. Mr Lomas was not handcuffed.

26. The next morning, Mr Lomas' blood oxygen levels were very low, and hospital staff gave him oxygen to help him breathe. They also gave him IV antibiotics to treat aspiration pneumonia (a chest infection caused by food or fluid in the lungs).

27. At around 10.50am, a prison manager phoned a bedwatch officer with Mr Lomas and told them that he should be restrained by an escort chain (a long cable attached at one end to the prisoner and at the other to a prison officer) to prevent him from wandering. The officer applied the escort chain as instructed.

28. On 1 May, following a deterioration in Mr Lomas' condition, the duty governor authorised the removal of the escort chain.

29. On 2 May, at around 9.00am, a doctor saw Mr Lomas and told the bedwatch officers that they were stopping all active treatment. One of the officers phoned a manager at Birmingham to ask them to contact Mr Lomas' next of kin.

30. Mr Lomas died in hospital at around 3.40pm.

Cause of death

31. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as aspiration pneumonia (a type of lung infection caused by inhaling food, liquid or saliva into the lungs leading to bacterial infection), caused by dementia (dementia can result in difficulties in swallowing which can lead to aspiration pneumonia).

Findings

Clinical findings

32. The clinical reviewer concluded that the care Mr Lomas received at Birmingham was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

33. The clinical reviewer found that Mr Lomas received comprehensive and compassionate nursing care at Birmingham. However, she had some concerns about the wider care Mr Lomas received, including that his GP reviews were often very short, decisions around prescribing were not detailed enough and concerns about the support provided by carers was not followed up with a safeguarding referral.

34. The clinical reviewer made eight recommendations relating to the wider care Mr Lomas received. While we do not repeat these here, the Head of Healthcare will wish to address them.

Use of restraints

35. 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 the prisoner's health and mobility. A judgment in the High Court in 2007 (known as the Graham judgement) 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 suffering from 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.

36. Mr Lomas was not handcuffed for his journey to hospital on the evening of 28 April. However, the next morning at 10.50am, a prison manager contacted the bedwatch officers and said that an escort chain should be applied to Mr Lomas.

37. The investigator spoke with the Head of Safety at Birmingham at the time, who said that the decision to apply the escort chain was made after a custodial manager received a phone call from escorting officers, who raised concerns that Mr Lomas was at risk of wandering and had been aggressive.

38. The Head of Safety said in hindsight, considering Mr Lomas' health at the time the escort chain was applied - specifically his low blood oxygen - it may not have been necessary to apply the escort chain. If this information, which was recorded in Mr Lomas' Person Escort Record (PER), had been shared with managers at the time, it might have led to the escort chain being removed earlier or avoided altogether.

39. The investigator found no record that escorting officers had phoned the prison to ask to apply an escort chain to Mr Lomas. There was also no evidence of Mr Lomas trying to get out of bed, wandering or being threatening to others.

40. The investigator spoke to an officer on the initial bedwatch who said that she did not raise any concerns about Mr Lomas' behaviour during the evening. She said he was confused and shouting at times, but he was not aggressive and was not able to get up without assistance.

41. The investigator also spoke to an officer who took over the bedwatch who said that she also had no concerns about Mr Lomas and did not ask to apply the escort chain. She said she received a phone call from a prison manager who told her that she needed to apply the escort chain.

42. It is unclear how the decision to apply restraints to Mr Lomas while he was in hospital came about. We consider that the use of restraints on Mr Lomas was inappropriate. He was 77 years old, with dementia and limited mobility. It is difficult to imagine how he would have escaped from two prison officers.

43. We have previously raised concerns about the inappropriate use of restraints at Birmingham. The Operational Security Group Director for HMPPS 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.

44. In a separate investigation, 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. He 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.

45. The Head of Safety 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.

46. Prison managers did not check Mr Lomas' current health when deciding to apply restraints. While we appreciate the escort chain was removed on 1 May, the decision to apply the escort chain was not in line with the Graham judgment. We recommend:

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

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

Inquest

47. At an inquest held on 3 December 2025, the Coroner concluded that Mr Lomas died of natural causes.

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