

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Martin (aka John) Casey, a prisoner at HMP Birmingham, on 9 January 2025**

**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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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.

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.

The deceased was known to prison and probation services as Mr John Casey. However, the coroner confirmed that the deceased was in fact Mr Martin Casey. It has since emerged that Martin and John Casey were brothers, and it remains unclear whether Martin or John committed the original offences. The deceased was recalled to prison on two occasions, and it is believed that he used the name John Casey as an alias. For the purpose of clarity, I will refer to the deceased as Mr Martin Casey throughout this report.

Mr Martin Casey died from an enlarged heart and synthetic cannabinoid intoxication on 9 January 2025 at HMP Birmingham. He was 59 years old. I offer my condolences to Mr Casey's family and friends.

Mr Casey was recalled to HMP Birmingham on 31 December 2024 after breaching his licence. There were no reported concerns about Mr Casey using illicit drugs in the time he was at Birmingham and I found no evidence that he was at risk of suicide or self-harm or that he took illicit substances with the intention of ending his own life.

The clinical reviewer concluded that the care Mr Casey received at Birmingham was partially equivalent to what he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

**February 2026**

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## Summary

### Events

1. On 5 July 2017, Mr Martin (aka John) Casey was remanded to HMP Birmingham. On 4 September, he was sentenced to nine years and three months in prison for kidnapping, burglary and theft offences, attempted robbery offences and racially/religiously aggravated common assault/ beating.
2. Mr Casey had a history of substance use. Between 2017 and 2022, he tested positive for drugs, was found under the influence of drugs and was found in possession of fermenting liquid. On two occasions, he was taken to hospital after suspected psychoactive substance use.
3. On 10 March 2022, Mr Casey was released from HMP Garth on licence. He was recalled twice, the last time being on 31 December 2024, for breaching the conditions of his licence and he was sent to HMP Birmingham.
4. Mr Casey was known to the prison's substance misuse service and was completing an alcohol detoxification programme. He had been given harm minimisation advice in relation to illicit substance use but declined ongoing support.
5. At 5.39pm on 9 January 2024, a few hours after a social visit with his partner, a prison officer found Mr Casey unresponsive on the floor of his cell. The officer called for staff assistance, and when staff responded, they radioed a medical emergency code. Prison officers and healthcare staff conducted cardiopulmonary resuscitation (CPR) until paramedics arrived and took over Mr Casey's care. At 6.58pm, paramedics pronounced life extinct.
6. The post mortem report concluded that Mr Casey died from an enlarged heart and synthetic cannabinoid intoxication.

### Findings

7. Mr Casey was the third prisoner to die from drug-related causes at Birmingham in three years. He had only been there for nine days before his death. There was one further drug-related death at the prison two days after Mr Casey's death. The prison reported a noticeable rise in illicit drug use in January 2025. Since Mr Casey's death, the prison plans to introduce tamper-proof vapes in October 2025, to prevent them being modified for drug use.
8. Mr Casey was known to the prison's substance misuse service and was completing an alcohol detoxification programme. He had been given harm minimisation advice in relation to illicit substance use but declined ongoing support.
9. The clinical reviewer concluded that the clinical care Mr Casey received at Birmingham was partially equivalent to what he could have expected to receive in the community.

## Recommendation

- The Head of Healthcare at HMP Birmingham must ensure that the '5 day SMS review' is a face to face contact, it includes a review of the SystemOne records beforehand and it incorporates a review of medication concordance as per BRT 'Standard Operating Procedures' and the Department of Health (DoH) 'Drug misuse and dependence UK guidelines on clinical management'.

## The Investigation Process

10. HMPPS notified us of Mr Casey's death on 9 January 2025.
11. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. NHS England commissioned an independent clinical reviewer, to review Mr Casey's clinical care at HMP Birmingham. The clinical review is attached as Annex 1.
13. The investigator and the clinical reviewer interviewed eight members of staff at Birmingham on 13 March 2025. They later interviewed one further member of staff on 10 September.
14. We informed HM Coroner for Birmingham and Solihull of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's office wrote to Mr Casey's family to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.
17. Mr Casey's family received a copy of the draft report. They did not make any comments.

## Background Information

### HMP Birmingham

18. HMP Birmingham is a category B adult male reception prison. It is managed by HMPPS. Birmingham and Solihull Mental Health NHS Foundation Trust provides healthcare services.

### Inspectorate of Prisons

19. The most recent inspection of HMP Birmingham was in March 2023. Inspectors reported drug supply was far lower than their last inspection in 2018, which may have been due to the significant investment in security arrangements to prevent the ingress of drugs and other contraband. However, there was no random mandatory drug testing, which meant leaders were not fully aware of the drugs being used in the prison or the extent of the problem.

### Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, published in December 2024, the IMB reported that the use of the X-ray body scanner had significantly reduced the amount of drugs and other illicit items being brought into the prison, but the prison continued to be troubled by drones transporting illicit items into the establishment.

### Previous deaths at HMP Birmingham

21. Mr Casey was the 17th prisoner to die at HMP Birmingham since January 2022. Of the previous deaths, 10 were from natural causes, three were self-inflicted, two were drug related, and one was a homicide. Up to the end of September 2025, there have been five deaths at Birmingham since Mr Casey's death, three were from natural causes, one in which the cause of death is currently unknown and one drug-related death which occurred two days after Mr Casey died.

### Psychoactive Substances

22. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.
23. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence.

Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

## Key Events

24. On 5 July 2017, Mr Martin (aka John) Casey was remanded to HMP Birmingham charged with various offences. On 4 September, he was sentenced to nine years and three months in prison for kidnapping, burglary and theft offences, attempt/robbery offences, and racially/religiously aggravated common assault/beatings.
25. Mr Casey served his sentence at various prisons. During this time, he was found under the influence of drugs and was found in possession of fermenting liquid. He was taken to hospital twice after suspected psychoactive substance use.
26. On 18 April 2021, while at HMP Garth, prison officers radioed a medical emergency code blue (indicating a prisoner is unconscious or is having difficulty breathing) after Mr Casey had a suspected heart attack. He was taken to hospital for treatment. Following his release in March 2022, he reported continued heart issues. In February 2023, he registered with a GP under the name 'Martin Casey' and told the GP that he had recently moved from Ireland.
27. On 7 November 2024, Mr Casey was recalled to prison for breaching his licence conditions. He was sent to HMP Birmingham. He reported a history of alcohol use but declined support from the substance misuse team. On 3 December, he was released from Birmingham on licence.
28. On 9 December, Mr Casey told his community offender manager that his name was Martin Casey. He said he had given a false name at some point and had since always been documented as John Casey. Mr Casey said he could provide his birth certificate to prove this.
29. On 31 December, Mr Casey was recalled to prison for breaching his licence conditions. He was sent to Birmingham.
30. At his reception health screen, Mr Casey said he had anxiety and depression. He said he had previously used drugs and was alcohol dependent. The nurse referred him to Birmingham Recovery Team (the prison substance misuse team) to complete an alcohol detoxification programme.
31. On 2 January 2025, a nurse from the Birmingham Recovery Team, accompanied by an officer, conducted a welfare check and completed an initial assessment. Mr Casey said that he did not have an issue with drugs or alcohol and declined support. The nurse gave him harm reduction advice and told him about the risks and effects of synthetic cannabinoids.
32. The nurse recorded in Mr Casey's medical record that the officer asked Mr Casey if he had been smoking cannabis or psychoactive substances as he had been tampering with vapes and the cell had a strong smell. However, the officer did not record this conversation in Mr Casey's prison record, and the officer could not be identified. There is no evidence that any follow-up action was taken.
33. On 5 January, another nurse from the Birmingham Recovery Team completed physical observations on Mr Casey as part of the substance misuse assessment.

Mr Casey said he was feeling depressed and was occasionally hearing voices. The nurse referred him to the mental health team.

34. Over the days that followed, staff did not raise any concerns about Mr Casey's behaviour or wellbeing.

### **Events of 9 January 2025**

35. The following account has been taken from documentary evidence provided by Birmingham, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.
36. At 2.00pm on 9 January, Mr Casey attended a social visit with his partner. He returned to the wing just after 4.00pm and spent some time speaking to other prisoners on the wing landing. He then collected his medication from the wing treatment hatch at 4.35pm.
37. At 4.37pm, 4.54pm and 5.04pm, Mr Casey used the phones on the wing landings to call his partner. They did not talk about anything of note. At 5.09pm, he returned to his cell after collecting his dinner from the wing canteen.
38. At 5.14pm, Officer A completed an additional welfare check on Mr Casey.
39. At 5.39pm, Officer A conducted a routine roll check. Officer A saw Mr Casey on the floor in his cell and radioed a code blue, which prompted the control room to call for an ambulance. Prison officers responded and started CPR.
40. At 5.40pm, healthcare staff responded. They moved Mr Casey out of his cell on to the wing landing to allow more space to treat him. Healthcare and prison staff continued to carry out CPR. A defibrillator was attached to Mr Casey and did not recommend a shock.
41. At 5.49pm, paramedics arrived and took over Mr Casey's care. After prolonged resuscitation attempts, they pronounced life extinct at 6.58pm.

### **Events following Mr Casey's death**

42. When police arrived at Birmingham, they seized two modified vapes from Mr Casey's cell for testing. Police confirmed the vapes contained synthetic cannabinoids.

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

43. The prison appointed Officer B as the family liaison officer. At 9.45pm on 9 January 2025, Officer B attended Mr Casey's next of kin's address to notify her of his death.
44. The prison contributed towards funeral costs in line with Prison Service policy.

### **Support for prisoners and staff**

45. After Mr Casey's death, a senior manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
46. The prison posted notices informing other prisoners of Mr Casey's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Casey's death.

### **Post-mortem report**

47. The post-mortem report concluded that Mr Casey died from cardiomegaly (an enlarged heart) and synthetic cannabinoid intoxication.

## Findings

### Illicit drug use and supply

48. Mr Casey was the third prisoner to die from drug-related causes at Birmingham in three years and had only been at the prison for nine days before his death. Since his death, there has been one further death attributed to drugs. The prison reported a noticeable rise in illicit drug use in January 2025. They have several methods to restrict the supply of drugs. Drug detection dogs are used to search the perimeter and grounds, while enhanced gate procedures have been introduced for all staff entering the prison. To specifically reduce the risk of psychoactive substances entering the prison, all legal visits have been made paperless, and incoming packages are subject to X-ray screening. Additionally, letters are photocopied before being delivered to the wings. Drug detection dogs are present to check all social visitors to reduce the risk of drugs being passed during visits.
49. Mr Casey was known to the prison's substance misuse service and he was completing an alcohol detoxification programme. He had been given harm minimisation advice in relation to illicit substance use.
50. On 2 January 2025, a nurse from Birmingham Recovery Team visited Mr Casey's cell for a welfare check, accompanied by a prison officer. Mr Casey declined support from the service. Medical records note that the officer asked Mr Casey if he had been smoking cannabis or psychoactive substances. However, this conversation was not recorded in Mr Casey's prison record, and the officer was not identified. It is unclear what, if any, follow-up action was taken. Mr C, Drug Strategy Lead at Birmingham, told the investigator that information about smells considered to indicate drug use coming from cells would not usually be escalated to his team, as it is a common occurrence in the prison. He said that unless they receive a significant amount of intelligence about the smell of illicit substances, no action would typically be taken.
51. Illicit drugs remain a widespread issue across the prison estate. Birmingham has taken steps to raise awareness among staff and prisoners and to reduce the supply of drugs. A major change is planned for 25 October 2025, when the prison will replace all current vapes with tamper-proof versions to prevent them being modified for drug use.
52. We are satisfied that Birmingham has a clear and comprehensive strategy for reducing demand and supply of illicit drugs, and that managers actively address any identified deficiencies.

### Clinical findings

53. The clinical reviewer concluded that the clinical care Mr Casey received at Birmingham was partially equivalent to what he could have expected to receive in the community.
54. She found that Mr Casey was appropriately referred to the chronic disease management nurse after he reported chest pains, however there is no evidence that this was further explored. She also found that on 5 January 2025, Mr Casey's

abnormal clinical observations were not followed up appropriately and the nurse responsible for actioning the abnormal results failed to document the actions that she said she had taken. The clinical reviewer found that Mr Casey was appropriately referred to the mental health team, however he died before he could be seen.

55. Mr Casey was appropriately prescribed medication to support him with the management of his alcohol withdrawal symptoms. However, between 31 December 2024 and 4 January 2025, he either refused or did not attend the medications hatch to receive six out of the nine prescribed doses. There is no evidence that the healthcare team discussed this with Mr Casey. The clinical reviewer made the following recommendation:

**The Head of Healthcare at HMP Birmingham must ensure that the '5 day SMS review' is a face to face contact, it includes a review of the SystemOne records beforehand and it incorporates a review of medication concordance as per BRT 'Standard Operating Procedures' and the Department of Health (DoH) 'Drug misuse and dependence UK guidelines on clinical management'.**

## **Inquest**

56. At the inquest held on 13 October to 16 October 2025, the Coroner concluded that Mr Casey's death was drug-related.

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