

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Styles, a prisoner at HMP Birmingham, on 18 July 2021

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*

OGL

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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Alan Styles, who was 85 years old, died from old age frailty on 18 July 2021, while a prisoner at HMP Birmingham. We offer our condolences to Mr Styles' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Styles received at the prison was equivalent to that he could have expected to receive in the community. She made no recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Styles' clinical care at the prison.
7. The PPO investigator has investigated the non-clinical issues in Mr Styles' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO's family liaison officer wrote to Mr Styles' next of kin, his grandson, to explain the investigation.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Birmingham

10. Mr Styles was the 10th prisoner to die at the prison since July 2019. Seven of the previous deaths were from natural causes, one was drug related and one was self-inflicted. There are no significant similarities between those cases and the death of Mr Styles.

Key Events

11. On 13 November 2020, Mr Alan Styles was sentenced to 20 years imprisonment for sexual offences and sent to HMP Birmingham.
12. At his initial health screen, healthcare staff identified that Mr Styles had a number of health issues relating to old age. He was allocated a cell on the health and social care ward, carers helped him with everyday needs.
13. On 10 December, following a discussion with a prison doctor, Mr Styles agreed to a Do Not Attempt Resuscitation order.
14. Mr Styles' health deteriorated between December 2020 and April 2021, and he was taken to hospital several times, both for investigations and to be admitted for treatment. In June 2021, prison staff noted that Mr Styles was becoming frailer.
15. On 1 July, Mr Styles went to hospital after choking on his drink. His condition deteriorated and the hospital decided to start end of life care. He was transferred to Willow House Hospice on 5 July, in accordance with his wishes. The Deputy Governor granted a special purpose licence with the condition that one prison officer stayed with him at the hospice. His grandson visited him in the hospice.
16. The prison discussed the early release on compassionate grounds process at an end of life meeting on 7 July. The paperwork was sent to the hospice to be signed by the Consultant on 15 July.
17. At 2.50am on 18 July, Mr Styles died. The prison offered to contribute to Mr Styles' funeral costs in line with national policy.
18. The coroner accepted the cause of death provided by a hospice doctor and no post-mortem examination was carried out. The doctor gave Mr Styles' cause of death as old age frailty.

Karen Johnson
Assistant Ombudsman

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