Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Tomlinson, a prisoner at HMP Birmingham, on 23 August 2022

A report by the Prisons and Probation Ombudsman

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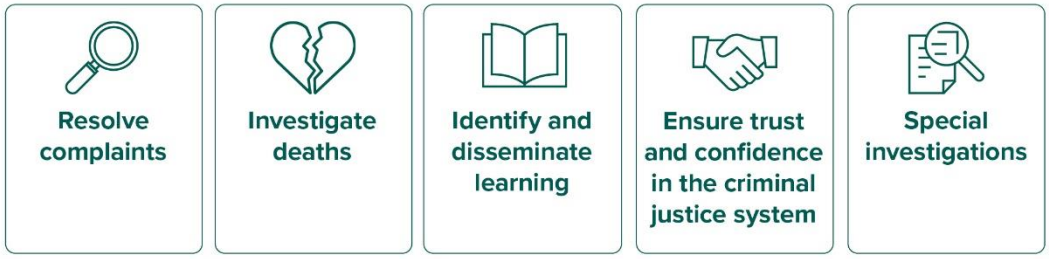
OUR VISION

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

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.

Mr Michael Tomlinson died on 23 August 2022 of a pulmonary embolism (a blood clot in the lung) at HMP Birmingham. He was 42 years old. I offer my condolences to Mr Tomlinson's family and friends.

Mr Tomlinson's death was sudden and unexpected. We found that staff at Birmingham provided a high level of support in difficult circumstances.

The clinical reviewer concluded that overall, the clinical care provided to Mr Tomlinson was equivalent to that which 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 **October 2023**

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Summary

Events

1. On 23 October 2020, Mr Michael Tomlinson, who identified as a Black British man according to his prison record, was recalled to prison for wounding with intent and grievous bodily harm. He was remanded to HMP Birmingham.

2. No significant health conditions were identified at Mr Tomlinson's initial health screening.

3. On 16 August, wing officers raised concerns about changes they had observed in Mr Tomlinson's behaviour following a period of isolation due to COVID-19. His cell was messy, and he was no longer collecting food from the servery. A nurse visited Mr Tomlinson to review his health, but he declined the appointment. The nurse referred Mr Tomlinson to the mental health team for an assessment.

4. The following day, two nurses checked on Mr Tomlinson. They found no changes in Mr Tomlinson's presentation and his room was still messy.

5. On 18 August, a mental health nurse reviewed Mr Tomlinson. She noted that his cell was 'chaotic'. Mr Tomlinson did not engage, so the mental health team rescheduled the review for a later date. Later that day, another mental health nurse and a custodial manager (CM) visited Mr Tomlinson to follow up. He said he was feeling stressed about his upcoming trial. They offered support and said they would visit Mr Tomlinson the following day.

6. Mr Tomlinson was seen by a nurse from the mental health team on a daily basis for three days from 19 – 21 August. Each time he stated that he was "ok" and there was nothing to be concerned about.

7. On 22 August, a mental health nurse reviewed Mr Tomlinson and noted that he was dishevelled, appeared anxious and low in mood. The nurse started Prison Service suicide and self-harm monitoring procedures (ACCT) and made a 24-hour referral to healthcare.

8. On 23 August at 10.44am, staff took Mr Tomlinson to the prison video link conference centre for his trial. Mr Tomlinson had become weak, so officers had to use a wheelchair to transport him. Mr Tomlinson complained of difficulty breathing and collapsed suddenly. An officer quickly called for help and performed cardiopulmonary resuscitation (CPR). Attempts to revive Mr Tomlinson were unsuccessful and Mr Tomlinson's death was pronounced at 11.44am.

9. A post-mortem examination established that Mr Tomlinson died from a pulmonary embolism (a blood clot in the lung) which was caused by deep vein thrombosis (DVT – a blood clot that develops within a deep vein the body).

Findings

10. The clinical reviewer concluded that the standard of clinical care provided to Mr Tomlinson was equivalent to that which he could have expected to receive in the community.

11. We found that the non-clinical care provided to Mr Tomlinson was of a high standard, particularly during the emergency response which must have been shocking for staff. We make no recommendations.

The Investigation Process

12. We were notified of Mr Tomlinson's death on 23 August 2022.

13. The investigator issued notices to staff and prisoners at Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Tomlinson's prison and medical records and interviewed seven members of staff.

15. NHS England commissioned a clinical reviewer to review Mr Tomlinson's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff.

16. 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.

17. The Ombudsman's family liaison officer contacted Mr Tomlinson's sister, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked for a copy of our report.

18. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

19. We also shared the report with Mr Tomlinson's sister, who did not respond.

Background Information

HMP Birmingham

20. HMP Birmingham is a local prison which holds up to 1,054 adult male prisoners. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) completed short scrutiny visits in November 2020 and January 2021. They reported that prison leaders had made progress against many of their recommendations, with significant work done to restore order to the prison. Inspectors reported that COVID-19 had created significant challenges for leaders at the prison. Inspectors also reported that the prison had worked to improve prisoner safety, but not all self-harm was reported or investigated.

Independent Monitoring Board

22. 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 for the year to June 2021, the IMB reported that the prison was safer than had it been previously, and that prisoners were treated fairly and with respect. The IMB said they had been assured that a previous delay in calling an emergency code blue, identified by the PPO during an investigation into a death in custody, had been addressed by the Governor.

Previous deaths at HMP Birmingham

23. Mr Tomlinson was the thirteenth prisoner to die at Birmingham in three years. Of the previous deaths, nine were from natural causes and three were self-inflicted.

Key Events

24. On 23 October 2020, Mr Michael Tomlinson, who identified as a Black British man, was recalled to custody for further offences and remanded to HMP Birmingham. Mr Tomlinson was charged with wounding with intent and grievous bodily harm.

25. During Mr Tomlinson's initial health screening, he shared his history of substance misuse with staff. A drugs test found illicit substances in Mr Tomlinson's system, and he was referred to the substance misuse service. No other significant health needs were identified.

26. Between Mr Tomlinson's recall to prison and July 2022, no significant health concerns or events were recorded by staff.

27. At the end of July, Mr Tomlinson contracted COVID-19 and was required to isolate in his cell for five days.

28. On 16 August, wing officers noticed that Mr Tomlinson's behaviour had changed. His cell was messy, and he had stopped collecting food from the servery. He had only fruit and snacks in his cell. Officers asked a nurse to review Mr Tomlinson in his cell. She found that Mr Tomlinson was well kempt, but his cell was in disarray. Mr Tomlinson said he did not want any help. She referred him to the mental health team for assessment.

29. The following day, two nurses checked on Mr Tomlinson. They found no changes in his presentation. Mr Tomlinson was still declining support from healthcare staff, but they arranged a healthcare visit for the following day, to check on him.

30. On 18 August, a nurse from the mental health team visited Mr Tomlinson to review his mental health. She noted that his cell was 'chaotic'. Mr Tomlinson continued to decline support, so she rescheduled the review for later that day.

31. At 5.58pm, a nurse and a custodial manager (CM) visited Mr Tomlinson in his cell. Mr Tomlinson said he was feeling stressed about his upcoming trial. In interview, the CM explained that he knew Mr Tomlinson quite well and based on his previous experience, a prisoner losing their appetite is common in the lead up to or during a trial, so he did not have any major concerns. The nurse recorded that Mr Tomlinson said he was eating lots of fruit, knew his cell was untidy and would tidy it. The nurse and CM arranged for the mental health team to visit Mr Tomlinson the following day.

32. Mr Tomlinson was seen by a mental health nurse on a daily basis for three days between 19-21 August. Each time he stated that he was "ok", wanted peace and quiet and there was nothing to be concerned about. Mr Tomlinson said he did not need any assistance.

33. On 22 August, the mental health nurse visited Mr Tomlinson and noted that he was dishevelled, appeared low in mood and anxious. She found half eaten food in his bin. She recorded her concerns and opened Assessment Care in Custody and Teamwork (ACCT) procedures to manage the risk of suicide and self-harm and made a 24-hour referral to healthcare.

34. On 23 August at 10.44am, Mr Tomlinson was transported to the video link conference centre to attend his trial. In interview, the officer who collected Mr Tomlinson, explained that he looked quite poorly. He had known Mr Tomlinson for over six years and had a good rapport with him. He assisted Mr Tomlinson with getting dressed and used a wheelchair to transport him to the centre, due to his lethargy.

35. On the way to the video link centre, Mr Tomlinson complained of difficulty breathing and collapsed suddenly. The officer immediately radioed a code blue (signalling an emergency and triggering a call to the ambulance service). Other prison officers and healthcare staff arrived as the officer began cardiopulmonary resuscitation (CPR). Healthcare staff helped the officer as he tried to revive Mr Tomlinson for approximately fifty minutes. Paramedics arrived and pronounced Mr Tomlinson's death at 11.44am.

Contact with Mr Tomlinson's family

36. On 23 August 2022, the prison appointed a family liaison officer. She contacted Mr Tomlinson's next of kin immediately following his death and maintained contact by telephone. She visited Mr Tomlinson's mother following his death and offered ongoing support.

37. Birmingham contributed towards the cost of Mr Tomlinson's funeral, in line with Prison Service policy.

Support for prisoners and staff

38. After Mr Tomlinson's death, managers held a debrief with 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.

39. Birmingham posted notices informing other prisoners of Mr Tomlinson's death and offering support.

Post-mortem report

40. The Coroner concluded that Mr Tomlinson died from a pulmonary embolism (a blood clot in the lung) which was caused by deep vein thrombosis. Mr Tomlinson also had a throat infection, which did not directly contribute to his death.

Inquest

41. The inquest into Mr Tomlinson's death concluded on 26 July 2023, with a verdict of natural causes.

Findings

42. The clinical reviewer concluded that the clinical care provided to Mr Tomlinson at Birmingham was equivalent to that which he could have expected to receive in the community. She makes recommendations for the Head of Healthcare to improve clinical practice in areas unrelated to Mr Tomlinson's death.

Good practice

43. We found the non-clinical care provided to Mr Tomlinson was of a high standard and make no recommendations. Wing staff were quick to act on their concerns when they noticed that Mr Tomlinson's behaviour (including the condition of his cell and his food intake) had changed.

44. We would also like to highlight the efforts made by staff during the emergency response. In particular, the actions of the officer who acted quickly and confidently to try to revive Mr Tomlinson in difficult circumstances. He should be commended for the care provided.

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