Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Theophilus Mapp, a prisoner at HMP Birmingham, on 29 August 2023

A report by the Prisons and Probation Ombudsman

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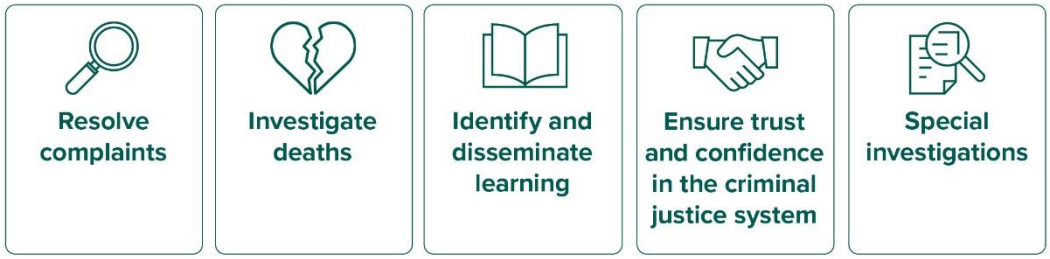
OUR VISION

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

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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 Theophilus Mapp died of gastric adenocarcinoma (stomach cancer) on 29 August 2023, while a prisoner at HMP Birmingham. He also had Type 2 diabetes which contributed to but did not cause his death. He was 88 years old. We offer our condolences to his family and friends.

4. NHS England commissioned an independent clinical reviewer to review Mr Mapp's clinical care at HMP Birmingham. He concluded that the clinical care Mr Mapp received at Birmingham was at least equivalent to the care he would have received in the community. He said that Mr Mapp received a good standard of multidisciplinary care from the healthcare team at HMP Birmingham. Clinical entries were detailed, decision making was good, and Mr Mapp received appropriate care for all his medical conditions. The clinical reviewer made no recommendations.

5. The PPO family liaison officer wrote to Mr Mapp's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She received no response.

6. The PPO investigator investigated the non-clinical issues relating to Mr Mapp's care. We did not find any non-clinical issues of concern. We make no recommendations.

7. The inquest into Mr Mapp's death was held on 15 January 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Mapp's death was due to metastatic gastric adenocarcinoma (stomach cancer). He also had Type 2 diabetes which contributed to but did not cause his death.

Adrian Usher **January 2024**
Prisons and Probation Ombudsman

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