Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Ash, a prisoner at HMP Birmingham, on 26 June 2024

A report by the Prisons and Probation Ombudsman

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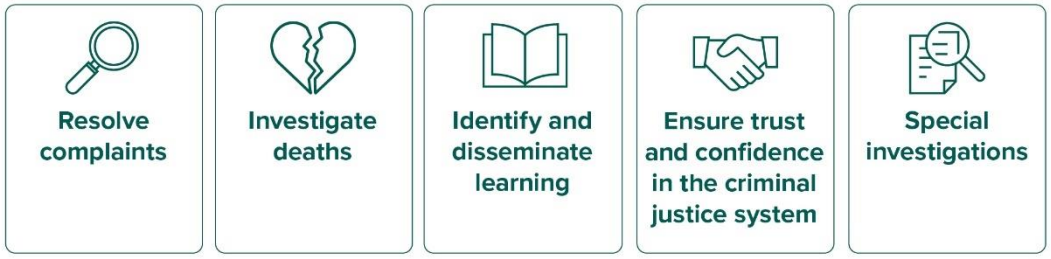
OUR VISION

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 Christopher Ash died of sudden unexplained death in schizophrenia on 26 June 2024, while a prisoner at HMP Birmingham. He also had a level of prescribed antipsychotic medication in his system which may have contributed to his death. He was 36 years old. We offer our condolences to his family and friends.

4. Mr Ash had been at Birmingham for just two days when he died, having recently transferred from a medium secure mental health unit.

5. The clinical reviewer concluded that the clinical care Mr Ash received at Birmingham was equivalent to that which he could have expected to receive in the community.

6. We found that the healthcare team, residential team, and safety team did not appropriately share information prior to Mr Ash being admitted to Birmingham. In addition, the checks on 26 June were insufficient.

Recommendations

- The Governor should introduce a robust quality assurance process to ensure that staff conduct routine roll checks and welfare checks in line with local and national guidelines.

The Investigation Process

7. HMPPS notified us of Mr Ash's death on 26 June 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Ash's clinical care at HMP Birmingham.

9. The PPO investigator investigated the non-clinical issues relating to Mr Ash's care. She interviewed 14 members of staff from Birmingham, two probation officers and a forensic psychologist from Reaside Clinic (a medium secure unit) between August and September. Most interviews were conducted with Ms Judith Bird.

10. The Ombudsman's office wrote to Mr Ash's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked us to consider why Mr Ash had not telephoned her on 25 June and what had happened to his property. These questions have been answered in separate correspondence.

11. Mr Ash's mother received a copy of the draft report. They did not make any comments.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Birmingham

13. Mr Ash was the 13th prisoner to die at HMP Birmingham since June 2021. Of the previous deaths, eight were from natural causes and four were self-inflicted. There are no similarities between the findings in our investigation into Mr Ash's death and the findings from our investigations into the previous deaths. Up to the end of January 2025, there have been three further deaths at Birmingham since that of Mr Ash. One was due to natural causes, one was self-inflicted, and one which is suspected to be due to drugs.

Key Events

14. Mr Christopher Ash had a history of substance misuse and mental health issues. He had been in prison several times before. In November 2021, Mr Ash was sentenced to 12 months imprisonment for an offence of arson. He was released from HMP Dovegate on 1 November 2022 to reside at an approved premises (accommodation provided by the Probation Service). Two days later, Mr Ash was recalled to HMP Birmingham for displaying aggressive behaviour towards approved premises staff.

15. Mr Ash transferred to HMP Lowdham Grange on 18 November. Staff had significant concerns about Mr Ash's mental health, and he was transferred to a medium secure unit, Reaside Clinic, on 20 December 2022. While at Reaside Clinic, he was treated for schizophrenia (a serious mental health disorder which can result in hallucinations, delusions and disorganised thinking) and prescribed clozapine and sodium valproate.

16. On 10 June 2024, a professionals' meeting was held at Reaside with a psychiatrist, a mental health nurse from HMP Birmingham, a community offender manager (COM) and Mr Ash. A Custodial Manager (CM) was invited to the meeting but did not attend. He told us that he had forgotten about the meeting (which was via MS Teams). Those present agreed that Mr Ash no longer needed treatment in a secure unit and that the nurse would recommend to the prison that Mr Ash should be accepted for transfer there to complete his prison sentence until he was due for release in November 2024. Mr Ash himself also said that he wanted to return to Birmingham.

17. The Head of Residence accepted Mr Ash back to Birmingham. He had not received minutes of the professionals' meeting before making this decision. He had only received an email from prison healthcare staff stating that they assessed Mr Ash as suitable to return to the prison and that he did not need to be located in the healthcare wing but could be on standard residential wing. He told us that even if he had received the notes, they would not have changed his decision, since it was healthcare staff's assessment that Mr Ash was fit to return.

18. On 12 June, staff discussed Mr Ash at the Safety Intervention Meeting (SIM), chaired by the Head of Safety. A mental health nurse and the mental health team leader were also present. In interview, they could not recall what information had been shared at the SIM. The only recorded notes were that Mr Ash would be returning to Birmingham on 24 June.

19. On 24 June, Mr Ash returned to Birmingham. The mental health team leader briefly met Mr Ash in reception for him to collect his prescription for clozapine (Mr Ash had to collect his medication from the medication hatch each day).

20. Mr Ash was located on the induction wing, and received three additional welfare checks through the night. Staff raised no concerns during these checks.

21. On 25 June, Mr Ash had his second day induction meeting with an officer in the wing office, and his secondary health screening with a pharmacy technician. They both raised no concerns about Mr Ash as a result.

22. A mental health nurse and a substance misuse worker also tried to speak to Mr Ash that day in his cell. However, Mr Ash declined to engage with them. He remained in his cell with his bed covers pulled over his head. Mental health staff planned to discuss Mr Ash at the multi-disciplinary team meeting the next day and a psychiatrist and a mental health nurse would also review him.

23. The investigator watched body worn video camera (BWVC) footage and listened to staff radio communications from 26 June. She also obtained information from the West Midlands Ambulance Service. CCTV was not available as it was not working on the induction wing on 26 June. The following account has been taken from all available sources.

24. On 26 June at approximately 5.40am, an officer completed the morning routine roll check of all prisoners on the wing by observing them through their cell door observation panels. She told us that Mr Ash did not appear to be medically unwell.

25. Between 6.50am and 7.30am, another officer completed the morning welfare check on all prisoners on the landing, including Mr Ash. During interview, he described this check as a, 'look through the door to see if everyone's there'. He told us that Mr Ash appeared to be sleeping in bed and it was dark in the cell. However, he stated that his main focus was another prisoner on the wing considered to be a risk to themselves, and not Mr Ash.

26. Morning unlock would usually occur between 8am and 8.30am. However, because it was a staff training day, this did not happen.

27. At 11.15am, two officers unlocked Mr Ash's cell to allow him to collect his medicine. They went into his cell and found Mr Ash lying fully dressed on his back, on his bed, unresponsive. The officers were shocked by what they had seen and left the cell to find healthcare staff. One officer radioed a code blue (emergency medical code signalling a prisoner is having difficulty or has stopped breathing). Control room staff immediately called an ambulance. A nurse was on the induction wing and went straight to Mr Ash's cell with an officer. They went into the cell, followed by another officer. The nurse and an officer placed Mr Ash on the floor and began CPR. The nurse told us that he believed Mr Ash had signs of rigor mortis (the stiffening of the body after death). At 11.17am, more healthcare staff arrived with the defibrillator, and they administered naloxone (used to reverse the effects of opioid overdose) at 11.31am. Paramedics arrived at 11.33am and took over Mr Ash's care. They pronounced life extinct at 11.40am.

28. At 12.10pm, the Head of Residence held a hot debrief with staff involved and ensured staff and prisoners were appropriately supported.

29. Police removed a vape pen, wraps of paper, and a white powder from Mr Ash's cell. Following testing, the white powder was identified as buprenorphine (used to treat opioid misuse and not prescribed to Mr Ash) and the vape tested positive for a synthetic cannabinoid.

Post-mortem report

30. The pathologist concluded that Mr Ash's cause of death was sudden unexplained death in schizophrenia.

31. The toxicology report concluded that the level of clozapine in Mr Ash's blood suggested excessive use or overdose of this drug. However, it was not clear whether the level was high enough to cause death in isolation. The pathologist concluded that the supratherapeutic (highly than is usually prescribed) level of clozapine was likely a contributing factor in Mr Ash's death, although they could not make a definite link between the level detected and Mr Ash's death.

32. Aside from the medications which Mr Ash was prescribed, the other medications found in his system were buprenorphine and zuclopenthixol (antipsychotic medication not prescribed to Mr Ash). The toxicology tests did not detect synthetic cannabinoids.

Findings

Clinical findings

33. The clinical reviewer concluded that the clinical care Mr Ash received was of the required standard and therefore equivalent to that which he would have received in the community. A nurse had attended his pre-discharge meeting at Reaside and Mr Ash himself had said that he wanted to return to Birmingham. Mr Ash had met his allocated nurse; Birmingham had received his discharge summary and were prepared for the monitoring of his medication. He was scheduled to be reviewed by a psychiatrist at the prison on the day he died.

34. Supratherapeutic levels of clozapine were found in Mr Ash's system post-mortem. The pathologist concluded that this may have contributed to his death. The levels of clozapine in Mr Ash's blood were higher than the recommended range when he arrived at Birmingham. Reaside Clinic had been aware of and considered this but were satisfied the prescribed dose was required to manage his mental illness and he did not appear to have exhibited or reported any significant side effects from it. Birmingham agreed to continue to monitor the clozapine levels once he arrived there.

Substance misuse

35. Mr Ash had an extensive history of substance misuse both in prison and the community. After his death, staff found buprenorphine and synthetic cannabinoids in his cell. Post-mortem tests on Mr Ash were positive for buprenorphine and antipsychotic medication which he had not been prescribed.

36. We do not know how Mr Ash obtained the illicit drugs in his possession. He had been at Birmingham less than 48 hours and there is no evidence he had contact with other prisoners, choosing to stay in his cell. It is possible he could have brought these items into the prison himself on transfer from Reaside, suggesting searching methods were insufficient. The Governor will want to consider this further.

Routine roll checks and welfare checks

37. Routine roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' Management of Internal Security Procedures Framework expects welfare checks to take place at roll checks including that staff are able to see the prisoner's face and satisfy themselves that they are alive and well. Before staff unlock a prisoner's door, they are also required to look through the observation panel and check the welfare of the prisoner.

38. An officer checked Mr Ash at 5.40am on 26 June. She said that there were no obvious signs that he was unwell. She also said that the early morning roll check was to make sure that were no major causes for concern rather than to check whether a prisoner is alive and well. When another officer conducted the welfare check just over an hour later, he also said he was just checking to see that Mr Ash

was in his cell and admitted that his main focus was on another prisoner on the landing.

39. Mr Ash had signs of rigor mortis when staff found him at 11.15am. These usually start several hours after death. We do not know when during the night Mr Ash became unwell. While the early morning checks did not require staff to obtain a response from him, it is clear that staff at Birmingham did not understand that routine roll checks and welfare checks were also intended to check the prisoner was alive. At interview, staff continued to tell us that the checks were just to make sure prisoners were in their cells.

40. Birmingham recognised that the welfare check by an officer was not adequate. On 28 June, the Acting Governor sent a Governor Direction informing staff that after the morning wing briefing, they must unlock and go into every cell. Staff must ensure that prisoners respond to them. This must occur before the regime takes place.

41. However, the officer told us that this action lasted around two weeks and then the staff again reverted to checking prisoners through their observation panels. The Head of Residence and the Head of Safety told us that they thought staff were going into cells as required. Following our interviews, the investigator spoke with the Head of Residence to inform her of the statement by the officer. She said she believed the checks were taking place but could provide no evidence to corroborate this. We make the following recommendation:

    The Governor should introduce a robust quality assurance process to ensure that staff conduct routine roll checks and welfare checks in line with local and national guidelines.

Governor to note

42. We agree with the clinical reviewer that there were issues with communication between healthcare staff and prison staff. Prison staff should have attended the professionals' meeting at Reaside but this did not happen. A CM was invited but forgot to attend.

43. The Head of Residence accepted the recommendation of the mental health nurse to accept Mr Ash to Birmingham without seeing the minutes of that meeting. Safer custody staff were only made aware of Mr Ash's imminent arrival on 12 June at the SIM. Neither the nurse or the mental health team leader could recall what information they shared in the SIM, and the Head of Safety reported receiving no additional information other than the date Mr Ash would be returning to Birmingham.

44. While we do not think that this had any bearing on Mr Ash's death, it is important that all departments are aware of relevant risk information when accepting prisoners from secure units. The Governor and Head of Healthcare will want to ensure that there is a clear process for this.

Inquest

45. At the inquest, held from 6 May to 12 May 2025, the coroner concluded that Mr Ash died of natural causes.

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

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