Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Holmes, a prisoner at HMP Birmingham, on 8 December 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

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. In August 2003, Mr Derek Holmes was sentenced to life imprisonment for wounding with intent. He was released in August 2017, but recalled to prison for breach of his licence in September 2022. He died in hospital of pneumonia caused by frailty of old age on 8 December 2023, while a prisoner at HMP Birmingham. Clostridium difficile (a bacterial infection) and dementia were noted by the Coroner as issues that contributed to but did not cause Mr Holmes' death. He was 80 years old. We offer our condolences to those that knew him.

4. We have not consulted Mr Holmes' family or friends about our investigation as neither the prison nor the police were able to identify any. After our report was published on our website, Mr Holmes daughter contacted us. She received a copy of the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Holmes' clinical care at Birmingham.

6. The clinical reviewer concluded that the clinical care Mr Holmes received at the Birmingham was of a good standard and equivalent to that which he could have expected to receive in the community. She made a recommendation not related to Mr Holmes' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Holmes' care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The inquest into Mr Holmes' death concluded that he died of natural causes.

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

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