Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Holland, a prisoner at HMP Liverpool, on 8 July 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

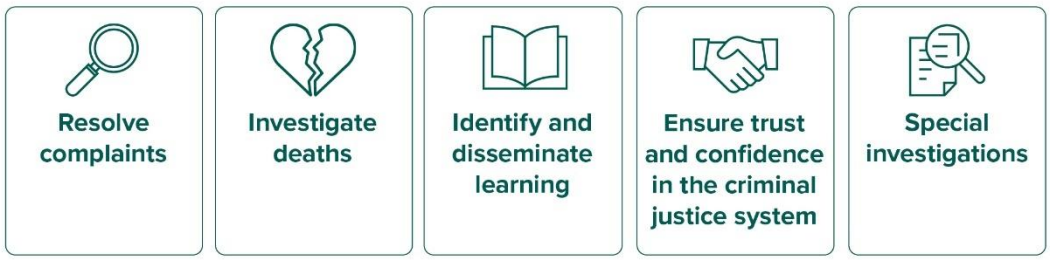
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Brian Holland died of pulmonary emphysema (a chronic lung disease) and heart disease, on 8 July 2024, while a prisoner at HMP Liverpool. He was 53 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Holland received at Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations directly related to the cause of Mr Holland's death. However, the Head of Healthcare will wish to consider recommendations on unrelated matters.

5. We found that officers who conduct welfare checks do not routinely hold radios and we are concerned that this could cause delays in communicating medical emergencies.

Recommendation

- The Governor should review the provision of radios to ensure that staff conducting welfare checks can radio emergency medical codes promptly.

The Investigation Process

6. HMPPS notified us of Mr Holland's death on 8 July 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Holland's clinical care at HMP Liverpool. The clinical review is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Holland's care. The investigator and the clinical reviewer interviewed six members of staff and a prisoner from HMP Liverpool on 20/27 August and 6 September 2024.

9. The Ombudsman's office wrote to Mr Holland's next of kin, his sister, to explain the investigation. She had no specific matters for the investigation to consider.

10. We sent a copy of our report to Mr Holland's sister. She did not report any factual inaccuracies.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendation.

Previous deaths at HMP Liverpool

12. Mr Holland was the 15th prisoner to die at HMP Liverpool since July 2021. Of the previous deaths, eight were from natural causes, four were self-inflicted and two were drug-related. We have previously raised concerns about the allocation of radios. Although this has led to a change in policy to ensure that all staff carry radios during night state, we remain concerned that they are not routinely held during the key task of welfare checks.

Key Events

13. Mr Brian Holland was convicted of theft, threatening behaviour and possessing a knife. On 12 February 2024, he was sentenced to 21 months imprisonment and taken to HMP Liverpool.

14. Nurse A conducted an initial health screen. He recorded Mr Holland's health conditions, which included high blood pressure, heart disease, a previous heart attack and mental health disorders. Mr Holland also had a history of substance misuse and opioid dependence, which was managed by a buprenorphine injection every 28 days. Nurse A referred him to the primary care, mental health and substance misuse services. The prison pharmacist then reviewed and re-prescribed Mr Holland's medication.

15. On 15 February, Mr Holland had a secondary health screen and a mental health review. (Care plans for hypertension and coronary heart disease were later created, with annual reviews for both conditions scheduled for 31 December.)

16. On 16 February, clinical and psychosocial substance misuse assessments were completed. Mr Holland continued to engage with the substance misuse service and received support over the following months.

Events of 8 July 2024

17. Officer A (also known as Officer B) completed a welfare check of Mr Holland and his cell mate, Prisoner A, at around 7.45am. He opened and looked through the cell observation panel. Both men appeared to be asleep and he did not try to get a response. Officer A then went to supervise the dispensing of medication.

18. At around 8.50am, Officer A heard Mr Holland's cell mate and other prisoners shouting for the cell door to be opened as Mr Holland was not "answering or reacting". When he opened the door, he immediately noticed that Mr Holland was discoloured and his head was swollen. As Officer A had no radio, he did not go into the cell but went to find another officer on the landing. He shouted to Officer C that he believed there was a code blue (a medical emergency in which a prisoner is unresponsive or has breathing difficulties) and asked if she had a radio. Officer C went to the cell, looked in and then radioed a code blue at 8.56am. The prison noted that an ambulance was requested at 8.58am.

19. Additional prison staff arrived, followed by several nurses and they moved Mr Holland to the floor. As rigor mortis and other signs of death were evident, they did not attempt resuscitation.

20. Paramedics pronounced life extinct at 9.13am.

21. A prison manager debriefed prison and healthcare staff and offered support. Notices were issued to other staff and prisoners, informing them of Mr Holland's death and signposting to avenues of support. Prisoner A was moved to another cell, where he was supported by a prison Listener (a prisoner trained by the Samaritans to provide confidential emotional support) and the mental health team.

22. Two prison managers visited Mr Holland's sister to inform her of Mr Holland's death and offer support. In line with the national policy, the prison contributed to the funeral expenses.

Post-mortem report

23. The report of the post-mortem examination concluded that the cause of Mr Holland's death was pulmonary emphysema with bronchopneumonia and ischaemic heart disease.

24. Toxicology tests found several prescription drugs in Mr Holland's blood. Some of them - quetiapine, carbamazepine, amitriptyline and mirtazapine - had not been prescribed to him but were largely within therapeutic levels. We were unable to establish how Mr Holland obtained these drugs.

Findings

Clinical findings

25. The clinical reviewer concluded that Mr Holland's clinical care for his physical conditions was of a good standard and equivalent to that which he could have expected to receive in the community. She noted that he had multiple health conditions with complex needs which were appropriately met by the healthcare team.

26. The clinical reviewer considered that some elements of mental healthcare did not meet the required standard. She also made two recommendations about record keeping and following up incidents of self-harm which the Head of Healthcare will wish to consider. We have not repeated those recommendations in this report, as the issues were unrelated to Mr Holland's death.

Non-clinical findings

Prison radios

27. Officer A was responsible for welfare checks on the morning of Mr Holland's death. When he was later called to the cell, he could not call an emergency code as he did not have a radio. He alerted a colleague, who also went to the cell to check and then radioed a code blue. Ms A, Head of Safety, said that radios are usually issued to three roles - the Supervising Officer, cleaning officer and moves officer – and spare radios are held that other staff can request if they wish, but it is not compulsory.

28. We have previously raised the allocation of radios in the context of limited provision during night state. We are pleased to note that the local policy has since been revised so that it is now a mandatory requirement for all staff to carry a radio when working overnight. However, we are concerned that it is not a requirement for officers who conduct welfare checks to hold radios, particularly as they might discover a medical emergency which needs to be communicated urgently. While the delay of several minutes in this emergency did not affect the outcome for Mr Holland, it could make a critical difference in other circumstances. We therefore believe it would be beneficial to extend the allocation of radios to staff who conduct welfare checks. We recommend:

    The Governor should review the provision of radios to ensure that staff conducting welfare checks can radio emergency medical codes promptly.

Governor to note

Requesting an ambulance in an emergency

29. The prison's handwritten log shows that a code blue was radioed at 8.56am and an ambulance was called at 8.58am. However, the ambulance service recorded that the call was received at 9.02am. While this delay did not affect the outcome for Mr Holland, the Governor will wish to establish whether it was due to a technical issue,

such as a disparity in clock timings, or an issue that requires further guidance to staff.

Inquest

30. At an inquest held on 6 February 2025, the coroner concluded that Mr Holland died from natural causes.

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

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100