



Independent investigation into the death of Mr Dean Holland, on 22 December 2023, following his release from HMP Featherstone.

A report by the Prisons and Probation Ombudsman

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



OGL

© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Dean Holland died of diabetic ketoacidosis on 22 December 2023, following his release from HMP Featherstone on 14 December 2023. He was 40 years old. We offer our condolences to those who knew him.
5. We did not find any issues of concern relating to the pre and post release planning. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Holland's death on 24 January 2024.
7. The PPO investigator obtained copies of relevant extracts from Mr Holland's prison and probation records.
8. We informed HM Coroner for Birmingham of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's office contacted Mr Holland's family to explain the investigation and to ask if they had any matters, they wanted us to consider. They did not respond.

Background Information

HMP Featherstone

10. HMP Featherstone is a closed category C training and resettlement prison. It is managed by HMPPS. The physical healthcare provider is Practice Plus Group, and the mental health provider is Inclusion (Midlands Partnership NHS Trust).

Probation Service

11. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

12. On 27 September 2021, Mr Dean Holland was convicted of drug offences and was sentenced to 27 months in prison. He was sent to HMP Bristol.
13. Mr Holland had diabetes and he was prescribed with appropriate medication to manage this condition. He also had a history substance misuse.
14. On 25 October, Mr Holland had a diabetic retinopathy screening (a procedure that involves checking the small blood vessels around part of the eye called the retina). His next appointment was arranged for 17 November, but Mr Holland did not attend.
15. On 23 November, a GP at the prison saw Mr Holland for a diabetic review. The GP gave Mr Holland a testing kit so that he could monitor his blood sugar levels independently. Over the months that followed, healthcare staff reviewed Mr Holland regularly. However, he was not always compliant with taking his medication and often failed to attend appointments to review his diabetes.
16. On 14 April 2022, Mr Holland was sent to Channings Wood.
17. A nurse completed Mr Holland's initial health screening and noted he needed to attend diabetic reviews to monitor his condition. Mr Holland attended his diabetes review on 24 August. Over the months that followed, healthcare staff continued to support Mr Holland with managing his diabetes.
18. On 17 June 2023, Mr Holland was released on Home Detention Curfew (HDC - a scheme which allows some people to be released early from custody if they have a suitable address) to BASS (Bail Accommodation Support Service) accommodation.
19. On 20 July, BASS staff contacted Mr Holland's community offender manager (COM) and told her that during a routine spot check of Mr Holland's room, they found seven spoons that they suspected were linked to heroin use, around 200g of cannabis and other drug paraphernalia. Mr Holland had also purchased a second phone and did not inform his COM. Mr Holland had breached his licence conditions and was recalled to prison that day. However, he was unlawfully at large (when an offender's licence has been revoked but they fail to take all the necessary steps to return to prison). The police arrested him on 14 August, and he was sent to HMP Birmingham the next day. He was due to be released on 14 December.
20. On 2 September, Mr Holland was transferred to HMP Featherstone. A nurse completed his initial health screen and noted that he had diabetes and referred him for a diabetic pack from the kitchen. He was provided with the diabetic packs with his meals to support his unstable sugar levels. He also received support from the substance misuse service.
21. On 4 September, a nurse made a note in Mr Holland's medical record that had not managed his diabetes correctly while in the community and that he needed to attend the diabetes review clinic. Healthcare staff reviewed Mr Holland's diabetes regularly and provided him with insulin, and equipment to test his blood sugar levels. They continued to advise him on how to manage his diabetes effectively and the importance of taking his insulin properly.

22. In preparation for Mr Holland's release, he was referred to Change Grow Live (CGL – a community drug and alcohol service) for ongoing support in the community. He also secured supported living accommodation. Mr Holland was required to register with a GP following his release for help with managing his diabetes.
23. On 14 December, Mr Holland was released from Featherstone at the end of his sentence. This meant that he was not subject to any licence conditions and did not need to engage with the Probation Service following his release. Healthcare staff provided Mr Holland with sufficient insulin to last him until he was able to register with a GP and he was provided with a naloxone kit (which can reverse the effects of an opioid overdose).

Circumstances of death

24. On 22 December, a member of the public discovered Mr Holland unconscious in a local park. They called the police and ambulance service. The paramedics attempted cardiopulmonary resuscitation but it was unsuccessful and they confirmed that Mr Holland had died. Mr Holland's blood glucose level was high, and he had ketones, suggesting diabetic ketoacidosis.

Post-mortem report

25. The post-mortem concluded that Mr Holland died of diabetic ketoacidosis.

Findings

Management of Mr Holland's diabetes

26. We are satisfied the prison supported Mr Holland with managing his diabetes in prison. The healthcare team at Featherstone reviewed him regularly, continued to provide advice on how to manage his diabetes and ensured they gave him a sufficient amount medication to last him in the community until he was able to register with a GP on his release.
27. We make no recommendations.
28. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
29. Mr Holland's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.

Inquest

30. The coroner concluded that no inquest would be required.

**Adrian Usher
Prisons and Probation Ombudsman**

July 2024



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

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

T 020 7633 4100