Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Lines, a prisoner at HMP Stafford, on 26 September 2025

A report by the Prisons and Probation Ombudsman

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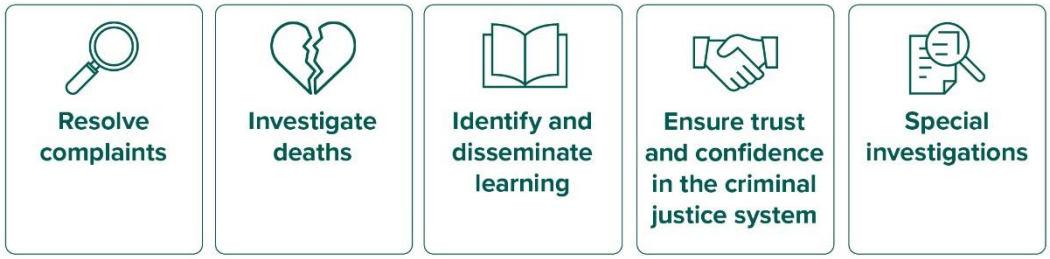
OUR VISION

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. On 3 May 2025, Mr Brian Lines was sentenced to 30 years in prison for rape. He died from decompensated heart failure secondary to an infection on 26 September 2025, while a prisoner at HMP Stafford. He was 86 years old. We offer our condolences to his family and friends.

4. The Ombudsman's office wrote to Mr Lines' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Lines' clinical care at HMP Stafford. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care that Mr Lines received at Stafford was of a good standard and was at least equivalent to that which he could have expected to receive in the community. She found that healthcare staff managed Mr Lines' health needs and episodes of acute illness well. She made one recommendation which was not related to Mr Lines' death but which the Head of Healthcare will want to address.

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

8. We did not identify any non-clinical issues of concern and we make no recommendations.

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

10. At an inquest held on 11 March 2026, the Coroner concluded that Mr Lines died of natural causes.

Adrian Usher **April 2026**
Prisons and Probation Ombudsman

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