

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Dennis Holness a prisoner at HMP Elmley on 14 February 2021

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Dennis Holness died on 14 February 2021 of sepsis (severe reaction to an infection) caused by bowel cancer at HMP Elmley. He was 89 years old. I offer my condolences to Mr Holness' family and friends.
4. The clinical reviewer concluded that overall, the clinical care Mr Holness received at Elmley was equivalent to that he could have expected to receive in the community. He made five recommendations but as none of them related to Mr Holness' death, we have not included them in this report.
5. We found delays in the compassionate release process. Two applications were started but neither reached the Governor for consideration.

## Recommendation

- The Governor should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Holness' clinical care at Elmley.
7. The PPO investigator has investigated non-clinical issues, including Mr Holness' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Holness' next of kin, his wife, to explain the investigation. Mr Holness' wife did not have any specific questions for us to consider but asked for a copy of the report.
9. Mr Holness' wife received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

### Previous deaths at HMP Elmley

11. Mr Holness was the 11th prisoner to die at Elmley since February 2019. Of the previous deaths, seven were from natural causes, two were self-inflicted and one was drug-related. We have previously made recommendations to Elmley about the management of the compassionate release process.

## Key Events

12. On 24 August 2015, Mr Dennis Holness was sentenced to 20 years in prison for sexual offences. He was taken to HMP Elmley where he had been on remand.
13. Mr Holness had bowel and prostate cancer, heart failure, atrial fibrillation (an abnormal heart rhythm) and hypertension (high blood pressure). In November 2016, he returned from hospital after suffering an intracranial haemorrhage (a bleed on the brain) and was admitted to the healthcare inpatient unit with an advanced care plan in place. Mr Holness said he did not want anyone to resuscitate him if his heart or breathing stopped and an order was completed to that effect. The order remained in place until his death.
14. In September 2020, Mr Holness returned from hospital following abnormal blood test results, with increased risk of infection. Future hospital admissions were not considered to be in his best interest and the hospital discharged him with a comprehensive palliative care plan which included one to one nursing.
15. In February 2021, Mr Holness' condition deteriorated. He died in prison on 14 February.
16. The Coroner recorded Mr Holness' cause of death as urosepsis and respiratory sepsis (severe reaction to an infection of the urinary tract) with pulmonary thromboembolism (blood clot on the lung), caused by bladder abscess and emaciation, which in turn was caused by bowel carcinoma (cancer) and diverticular disease (a bowel condition). Atrial fibrillation and hypertension were listed as contributory factors.

## Non-Clinical Findings

### Compassionate release

17. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
18. In 2017, an application for Mr Holness' early release on compassionate grounds was rejected by the Secretary of State. The prison started two further applications for early release, the first in March 2019 and a second in September 2020.
19. The process for compassionate release requires input from a registered medical practitioner and from a probation officer or offender manager covering the prisoner's health, the risk he or she continues to pose and the support available. The Prison Governor, armed with the information provided, then decides whether or not to support early release. If supported, the application goes to the Public Protection Casework Section of HMPPS for a decision. It is considered good practice for a nominated person to oversee the process to ensure that it proceeds without unnecessary delay.
20. The applications started in in March 2019 and September 2020 were poorly managed. The application documents provided by the prison were incomplete, with important information missing. There is no evidence that any one person was responsible for collating and chasing the information to ensure that they were progressed quickly and neither application reached the Governor for consideration.
21. The Head of Offender Management at Elmley told the investigator that they recognised the previous failings, that the individuals involved had received advice and training and that future applications would be carefully managed.
22. It is not possible to say if Mr Holness would have been granted compassionate release, however, we are concerned that neither application was properly managed. We make the following recommendation:

**The Governor should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.**

**Louise Richards**  
**Assistant Ombudsman**

**June 2021**

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