Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Elener, a prisoner at HMP Holme House, on 22 August 2024

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

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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 29 March 2004, Mr Derek Elener was sentenced to 23 years and eight months in prison for murder. He died of Urosepsis (a life threatening syndrome cause by a urinary tract infection) on 22 August 2024, while a prisoner at HMP Holme House. He was 85 years old. We offer our condolences to Mr Elener's family and friends.

4. The Ombudsman's office wrote to Mr Elener's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Elener's family asked why Mr Elener was not placed in a care home and asked for a copy of our report. We have answered this question in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Elener's clinical care at Holme House.

6. The clinical reviewer concluded that the clinical care Mr Elener received at Holme House was of a good standard and equivalent to what he could have expected to receive in the community. She found evidence of excellent individualised end of life care planning. The clinical reviewer made recommendations not related to Mr Elener's death which the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Elener's care. We did not find any non-clinical issues of concern. We make no recommendations.

Good Practice

8. The clinical reviewer noted that Mr Elener had a named nurse who coordinated his complex care needs. There was evidence of kind, respectful and compassionate interactions between the healthcare team, custodial staff and Mr Elener.

9. The healthcare team appropriately supported Mr Elener with his early release on compassionate grounds (ERCG) application and an Independent Advocate was appointed to provide additional support during this process.

10. Mr Elener's family told us that the prison Family Liaison Officer provided excellent support to the family before and after Mr Eleanor's death.

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

12. Mr Elener'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.

13. At the inquest held on 27 November 2024, the coroner concluded that Mr Derek Elener died of natural causes.

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

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