Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Moore, a prisoner at HMP Wymott, on 7 July 2023

A report by the Prisons and Probation Ombudsman

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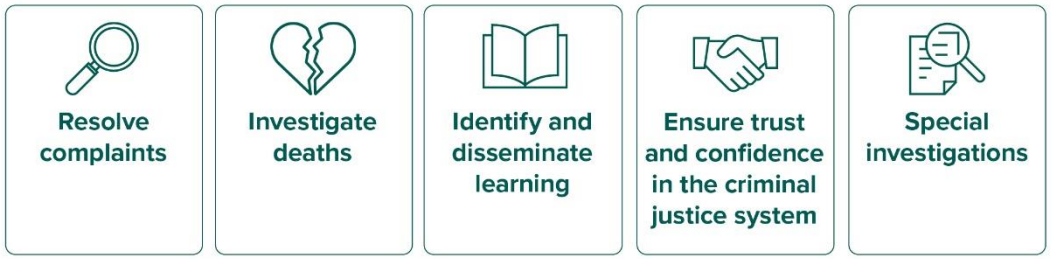
OUR VISION

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. In October 2006, Mr Donald Moore received an Indeterminate sentence for Public Protection (IPP) for sexual offences. He received a minimum term of four years, nine months and 26 days. Mr Moore died of disseminated malignant mesothelioma on 7 July 2023, at HMP Wymott. He was 82 years old. We offer our condolences to Mr Moore's family and friends.

4. The PPO family liaison officer wrote to Mr Moore's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

5. NHS England commissioned an independent clinical reviewer to review Mr Moore's clinical care at HMP Wymott.

6. The clinical reviewer concluded that the clinical care Mr Moore received at HMP Wymott was variable. Some areas of Mr Moore's care were equivalent to what he could have expected to receive in the community. However, she found some areas of learning for the healthcare team relating to the limited monitoring of Mr Moore's condition and adherence to NICE guidance for fall risk assessments. The clinical reviewer made recommendations not related to Mr Moore's death that the Head of Healthcare will wish to address.

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

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

9. At the inquest held on 1 May 2024, the coroner concluded that Mr Moore died of the industrial disease of mesothelioma.

Adrian Usher **March 2024**
Prisons and Probation Ombudsman

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