Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Moore, a prisoner at HMP Rye Hill, on 29 July 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

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 November 2017, Mr William Moore was sentenced to 20 years imprisonment for several sexual offences. He died of metastatic malignant melanoma (skin cancer which has spread to other parts of the body) on 29 July 2024 in hospital, while a prisoner at HMP Rye Hill. He was 67 years old. We offer our condolences to Mr Moore's family and friends.

4. The Ombudsman's office wrote to Mr Moore's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

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

6. The clinical reviewer concluded that the clinical care Mr Moore received at Rye Hill was of a good standard and equivalent to that which he could have expected to receive in the community. She found that there was clear evidence of care planning for the management of long-term conditions and end of life care. The clinical reviewer made no recommendations.

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. Mr Moore's next of kin received a copy of the draft report. They did not make any comments.

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

Inquest

The inquest into Mr Moore's death concluded on 30 January 2025. It found that Mr Moore died of skin cancer and that diabetes contributed to but did not cause his death. The Coroner concluded that Mr Moore died of natural causes.

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