

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Rocks, a prisoner at HMP Hull, on 26 July 2023

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

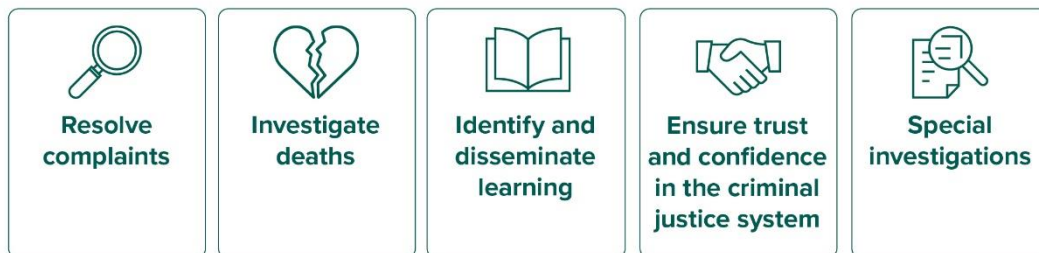
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OUR VISION

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 24 May 2023, Mr Daniel Rocks was convicted of intentional strangulation and sent to HMP Hull. In June he was sentenced to 18 months. He died of coronary heart disease on 26 July, at Hull. He was 46 years old. We offer our condolences to Mr Rocks' family and friends.
4. The PPO family liaison officer wrote to Mr Rocks' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They said they wanted to know what had happened to Mr Rocks' belongings and asked for a copy of the PPO report. The prison later confirmed that Mr Rock's belongings had been given to his next of kin.
5. The PPO investigator investigated the non-clinical issues relating to Mr Rocks' care. We did not find any non-clinical issues of concern.
6. NHS England commissioned an independent clinical reviewer to review Mr Rocks' clinical care at Hull.
7. The clinical reviewer concluded that the clinical care Mr Rocks received at Hull was of a reasonable standard and partially equivalent to that which he could have expected to receive in the community.
8. The clinical reviewer made recommendations not related to Mr Rocks' death that the Head of Healthcare will wish to address, and one related to his death. We endorse and repeat that recommendation:

The Head of Healthcare should ensure that all healthcare staff adhere to NICE Guidance [NG28] for patients presenting with raised blood glucose levels.
9. We shared our initial report with HMPPS and the prison healthcare provider, Spectrum CIC. They found no factual inaccuracies. Spectrum CIC provided an action plan which is annexed to this report.
10. We sent a copy of our initial report to Mr Rocks' next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

April 2024

Inquest

The inquest, held on 15 October 2024, concluded that Mr Rocks died from natural causes.

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