Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Moyle, a prisoner at HMP Hull, on 20 June 2024

A report by the Prisons and Probation Ombudsman

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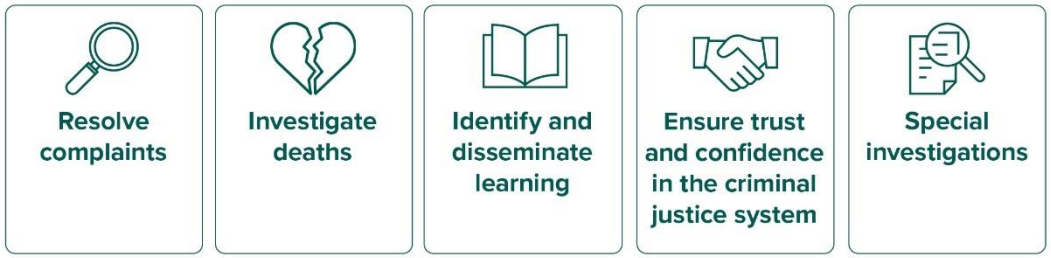
OUR VISION

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

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. 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. Mr Raymond Moyle died of acute myocardial ischaemia (a lack of blood flow to the heart muscle) on 20 June 2024, while a prisoner at HMP Hull. This was caused by heart disease. He was 76 years old. I offer my condolences to Mr Moyle's family and friends.

4. The clinical reviewer concluded that the healthcare Mr Moyle received at Hull and HMP Moorland, Mr Moyle's previous prison, was equivalent to that which he could have expected to receive in the community. She made one recommendation which was not directly related to Mr Moyle's death but which the Head of Healthcare at Hull will want to address.

5. Hull told us that they could not find the escort risk assessments for Mr Moyle's escorts to hospital on 22 May and 3 June 2024. While staff confirmed that Mr Moyle was not restrained on 22 May, we found that he was inappropriately restrained with an escort cable on 3 June.

6. The Head of Security told us that he signed the escort risk assessments, and both directed that no restraints should be used due to Mr Moyle's age and mobility. The custodial manager present for the escort on 3 June confirmed that an escort cable was used. He told us that he was unable to recall what the risk assessment stated but said that he would have followed it. We were therefore unable to determine why Mr Moyle was restrained.

Recommendations

The Governor should ensure that:

- **escort staff should question the escort risk assessment and review previous assessments if there are clear indications that restraints should not be used; and**

- **escort risk assessments are retained and stored securely in line with retention policies and General Data Protection Regulation (GDPR) requirements.**

The Investigation Process

7. HMPPS notified us of Mr Moyle's death on 20 June 2024.

8. NHS England commissioned a clinical reviewer to review Mr Moyle's clinical care at the prison.

9. The PPO investigator investigated the non-clinical issues relating to Mr Moyle's care.

10. The investigator and clinical reviewer interviewed three members of staff at HMP Moorland between 30 July and 14 August.

11. We informed HM Coroner for Doncaster of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Moyle's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

13. The initial report was shared with HM Prison and Probation Service (HMPPS) and Spectrum, Community Health. HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Hull

14. Mr Moyle was the fifteenth prisoner to die at Hull since 19 June 2021. Of the previous deaths, thirteen were from natural causes and one was self-inflicted. There are no previous similar recommendations.

Key Events

15. On 5 August 2019, Mr Raymond Moyle was sentenced to six years imprisonment for sexual offences.

16. In 2019, a Personal Emergency Evacuation Plan (PEEP) was put in place for Mr Moyle due to his restricted mobility.

17. On 20 May 2022, Mr Moyle was released from HMP Holme House on his conditional release date.

18. On 24 August 2023, Mr Moyle was recalled to HMP Hull after displaying persistent sexualised behaviour in the community. A nurse completed an initial health screen with Mr Moyle and noted a number of health conditions. Mr Moyle received daily social care during his time at Hull.

19. On 10 October, Mr Moyle attended a podiatry appointment at hospital. An escort risk assessment was completed which stated that due to his poor mobility, no restraints should be applied unless he was non-compliant.

20. On 31 October, a care plan was created for Mr Moyle's heart failure which was to be reviewed annually.

21. On 22 January 2024, healthcare conducted a blood test for Mr Moyle. Two days later, as a result of abnormal results from the test, Mr Moyle was admitted to A&E. He also had chest pain which the hospital confirmed was hypoglycaemia (low blood sugar). The escort risk assessment stated that no restraints were to be used unless Mr Moyle did not comply. This was on the basis that Mr Moyle had low mobility and was historically compliant. He was discharged from hospital that day.

22. On 7 May, Mr Moyle had an electrocardiogram (ECG), the results of which were abnormal. A code blue was called, and he was admitted to hospital. An escort risk assessment was completed, which stated that restraints should not be used due to Mr Moyle's age and mobility.

23. On 8 May, Mr Moyle was discharged from hospital.

24. On 22 May, a code blue was called, and Mr Moyle was admitted to A&E after having chest tightness and pain. The escort officer told us that no restraints were used for this escort in line with the risk assessment. However, Hull did not provide us with a copy of the escort risk assessment because they could not find it.

25. On 23 May, Mr Moyle discharged himself from A&E. A GP operating at Hull saw Mr Moyle. He noted that Mr Moyle attended A&E for suspected heart failure and discharged himself due to "not having food and shifting from one place to another inside hospital". Mr Moyle denied having chest pain when the GP saw him. Healthcare staff monitored him daily until 30 May.

26. On 3 June, Mr Moyle was found on his cell floor. He told staff that he had had a fall the previous night and his care buddy helped him to bed. A GP operating at Hull assessed Mr Moyle and confirmed that he needed to go to hospital. A Custodial Manager (CM), who attended the escort, told us that Mr Moyle was restrained with

an escort cable. Hull could not find the escort risk assessment, so it is not clear why he was restrained. When Mr Moyle was admitted to hospital, it was confirmed that he had a broken hip and needed surgery, so his restraints were removed.

27. On 5 June, Mr Moyle underwent hip surgery in hospital.

28. On 6 June, a nurse contacted the hospital. They advised that Mr Moyle needed physiotherapy. As it was not suitable for Mr Moyle to return to Hull because of his caring needs, she referred him to HMP Moorland for rehabilitation on their Intermediate Care and Reablement Service (ICRS).

29. On 14 June, a prison family liaison officer spoke to bed watch officers who told him that Mr Moyle's condition had deteriorated. Prison staff tried to contact Mr Moyle's next of kin to inform them. On 18 June, Mr Moyle's daughter confirmed that the hospital had been in touch.

Events of 19 June

30. At 4.30pm, Mr Moyle was discharged from hospital to the ICRS at Moorland. As this was a temporary transfer, Mr Moyle formally remained a Hull prisoner. A nurse recorded in his medical records that his reception screen would be completed the following day as he had fallen asleep.

31. At 6.20pm, a healthcare assistant saw Mr Moyle and completed observations. She noted that he had not eaten his dinner as he was not hungry.

32. At approximately 7.30pm, a nursing associate told us that she looked through Mr Moyle's cell observation panel to check he was breathing, and reported back to a nurse that his chest was rising and falling.

33. At 11.36pm, the nursing associate went into Mr Moyle's cell to take observations and administer medication. Mr Moyle was unresponsive, and she could not find a pulse. She called for a nurse to attend, and she started CPR. A CM called a code blue. CPR continued until the nurse tried to insert an airway and found that rigor mortis (the stiffening of the body after death) had set in. CPR was therefore stopped.

34. At 12.08am on 20 June, it was confirmed that Mr Moyle had died.

Post-mortem report

35. The post-mortem report concluded that Mr Moyle died of acute myocardial ischaemia, caused by ischaemic heart disease, which was in turn caused by severe coronary artery atheroma. Mr Moyle also had chronic kidney disease which did not cause but contributed to his death.

Inquest

36. At an inquest held on 6 June 2025, the Coroner concluded that Mr Moyle died of natural causes.

Non-Clinical Findings

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

38. The Graham judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

39. HMP Hull could not find the escort risk assessments for Mr Moyle's hospital attendance on 22 May and 3 June.

40. The Head of Security told us that he signed the escort risk assessments. He said that both directed that no restraints should be used due to Mr Moyle's age and mobility. He was therefore unable to explain why restraints were used on 3 June after Mr Moyle was found on his cell floor, with a suspected broken hip.

41. The CM who attended the escort on 3 June, confirmed that Mr Moyle was restrained with an escort cable and was transported to the ambulance on a bed. He told us that once Mr Moyle arrived at the hospital, and they confirmed that he had a broken hip, a new risk assessment was completed, and the restraints were removed. He also said that he was unable to recall what the escort risk assessment stated but he said that he would have followed it.

42. The CM told us that he had no prior knowledge of Mr Moyle's previous escorts and was therefore unaware that restraints had not been used previously. He said that if he had known this, he would have raised a concern about Mr Moyle being restrained for this escort. However, he confirmed that he was aware that Mr Moyle had a suspected broken hip. Hull also provided a copy of Mr Moyle's mercury report which showed that there had been no incidents during previous escorts to justify the use of restraints.

43. In light of this, and as Mr Moyle was transported in a bed, restraints should not have been used for this escort. It is concerning that Hull have misplaced both escort risk assessments. Although we are unable to confirm whether the escort risk assessment was followed on 3 June, there were clear indications that restraints should not have been used and that staff should have raised concerns about the use of restraints. We therefore make the following recommendation:

The Governor should ensure that:

- **escort staff should question the escort risk assessment and review previous assessments if there are clear indications that restraints should not be used; and**
- **escort risk assessments are retained and stored securely in line with retention policies and General Data Protection Regulation (GDPR) requirements.**

Governor to note

44. Hull told us that as Mr Moyle had transferred to Moorland, notices were not published to inform staff and prisoners of his death. As Mr Moyle was classed as a prisoner at Hull at the time of his death and was planning to return to Hull following his rehabilitation, it would have been appropriate for notices to be published.

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

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