

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gerald Goff, a prisoner at HMP Dartmoor, on 22 February 2020

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Gerald Goff died on 22 February 2020 of pneumonia while a prisoner at HMP Dartmoor. He also had chronic obstructive pulmonary disease (COPD) which contributed to but did not cause his death. He was 73 years old. We offer our condolences to his family and friends.
4. The clinical reviewer was satisfied that the standard of healthcare that Mr Goff received at Dartmoor was good and equivalent to that which he could have expected to receive in the community. Prison staff promptly told healthcare staff when they found out that Mr Goff had been unwell. A nurse assessed him promptly and he was appropriately transferred to hospital as an emergency.
5. We did not identify any non-clinical issues of concern and we make no recommendations.

### Investigation process

6. NHS England commissioned an independent clinical reviewer to review Mr Goff's clinical care at the prison. The clinical review is attached to this report at Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Goff's care, including his location, the security arrangements for his hospital escorts and liaison with his family.
8. The PPO family liaison officer wrote to Mr Goff's next of kin to explain the investigation. She did not respond.
9. We shared the initial report with the prison service. There was one factual inaccuracy and this report has been amended accordingly.
10. This version of the report, published on the website, has been amended to remove the names of staff and prisoners involved in my investigation.

### Previous deaths at Dartmoor

11. Mr Goff was the seventh prisoner to die at Dartmoor since February 2018. Four of the previous deaths were from natural causes and two were self-inflicted. There were no significant similarities between our findings in this investigation and those of the previous deaths.

### Key Events

12. On 23 October 2014, Mr Goff was sentenced to 20 years in prison for sex offences. On 17 March 2017, he was transferred to HMP Dartmoor. Mr Goff had

no known health concerns which required attention, he took no prescribed medications and remained well for the next three years.

13. On 3 February 2020, Mr Goff told an officer that he had had a chesty cough for two weeks. The officer told healthcare staff by telephone that Mr Goff was feeling unwell. A nurse saw Mr Goff promptly and noted that he had a high pulse rate (107 beats per minute), a high temperature (38.2 degrees), and low blood oxygen saturation (86%). The nurse gave him oxygen and sent him to hospital by emergency ambulance because she thought that he may have sepsis. He was admitted to hospital.
14. On 6 February, Mr Goff's condition deteriorated, and he was moved to the intensive care unit. On 22 February, Mr Goff died of pneumonia in hospital.

**Caroline Mills**  
**Assistant Ombudsman**

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