

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Derek Booth, a prisoner at HMP Moorland, on 4 November 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 Derek Booth, a prisoner at HMP Moorland, died in hospital on 4 November 2020. The cause of death was cancer of the bile duct. He also had underlying heart disease. Mr Booth was 80 years old. I offer my condolences to his family and friends.
4. The clinical reviewer found that Mr Booth's care at Moorland was variable. Notably, his high blood pressure and heart disease were not managed in line with the national guidelines for cardiovascular disease; relevant care plans were not in place; missed appointments were not appropriately followed up; and when Mr Booth's condition deteriorated on 23 September, he was not assessed by a registered nurse, so there was a missed opportunity for an early referral to secondary care for a diagnosis. (Although an earlier diagnosis would not have affected the outcome for Mr Booth, it might make a crucial difference in other cases.)
5. Despite some good practice, the clinical reviewer concluded Mr Booth's care was not equivalent to that he could have expected to receive in the community. Full details of the findings are in the clinical review report. The clinical reviewer made nine recommendations, which the Heads of Healthcare at Moorland and HMP Leeds will need to address. We recast and repeat those linked to the cause of Mr Booth's death.
6. We found no non-clinical issues of concern. However, we commend as good practice the high standard of record keeping, information sharing and engagement by operational staff and ask that the Governor shares this with the staff concerned.

## Recommendations

- The Head of Healthcare at HMP Moorland should ensure that healthcare staff manage long-term medical conditions in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- The Head of Healthcare at HMP Moorland should ensure that nursing care plans are put in place for those with long-term conditions.
- The Head of Healthcare at HMP Moorland should ensure that the escalation process is followed when an unregistered member of staff identifies health issues that need to be assessed by a registered nurse.

- The Head of Healthcare at HMP Moorland should ensure that prisoners who fail to attend for medical appointments are followed up, in line with the local policy.
- The Head of Healthcare at HMP Leeds should ensure that blood tests are arranged and followed up promptly.
- The Head of Healthcare at HMP Leeds should ensure that there is a robust and auditable process for prescribing statins and other medication.
- The Governor should ensure that the Ombudsman's commendation is shared with the key worker, as well as the other wing and bedwatch staff responsible for Mr Booth's care.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Booth's clinical care at HMP Moorland.
8. The PPO investigator investigated non-clinical issues, including Mr Booth's location, the security arrangements for his hospital escort/s, liaison with his family and whether compassionate release was considered.
9. The clinical reviewer and investigator interviewed two healthcare staff and a prison officer on 14 December 2020. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic and summaries are attached as annexes.
10. The PPO family liaison officer wrote to Mr Booth's next of kin, his partner, to explain the investigation. She did not respond to our letter.
11. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

### Previous deaths at HMP Moorland

12. Mr Booth was the fifth prisoner to die at Moorland since November 2018. There has since been another death. All the deaths were from natural causes. We have previously found that clinical escalation procedures had not been appropriately followed.

## Key Events

13. Mr Derek Booth was convicted of sexual offences on 31 January 2019. He was sentenced to nine years imprisonment and sent to HMP Leeds. Mr Booth moved to HMP Moorland on 5 July 2019.
14. Mr Booth had several chronic medical conditions, including heart disease, high blood pressure, high cholesterol levels and poor hearing.
15. In March 2020, Mr Booth received information about the COVID-19 pandemic and managing the risks. He chose to shield and, each day, he was offered the opportunity to see a nurse if he felt unwell.
16. On 14 July, an Advanced Nurse Practitioner examined Mr Booth at the request of his key worker, who was concerned about his general health. He was found to be very dehydrated and confused and had only been eating and drinking small amounts. A prison GP reviewed him the next day and requested blood tests and a chest X-ray.
17. On 11 August, Mr Booth was informed that the chest X-ray had identified an abnormality in one of his lungs and he was referred to a respiratory consultant, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.
18. The respiratory consultant notified Mr Booth on 25 August that a CT scan had shown the lung abnormality was insignificant, but it had identified a mass that could indicate pancreatic cancer. He therefore referred him to a gastrointestinal specialist. Mr Booth underwent tests in September, including a further CT scan which showed no evidence of a mass. He was therefore discharged.
19. On 23 September, wing staff asked a healthcare assistant to check Mr Booth, as his skin was yellow. She found that his urine was very dark, and he had lost weight. After completing clinical observations and using an assessment tool to determine the severity of his illness, she reported the findings to a nurse. However, no further action was taken at that time. Over the following days, officers recorded several times that Mr Booth remained unwell. They sought help from healthcare and encouraged Mr Booth to book an appointment with the GP.
20. Due to continuing concerns about Mr Booth's health, an officer took him to see a nurse on 30 September. The Advanced Nurse Practitioner and a nurse later examined him in his cell. He had symptoms of jaundice, together with poor appetite and recent weight loss. The nurse spoke to the gastrointestinal department at Doncaster Royal Infirmary and agreed to send him for assessment the next day.
21. Mr Booth was taken to hospital on 1 October. He was escorted by two prison officers and no restraints were used. Release on temporary licence (ROTL) was considered but not approved. (A further application for ROTL was started when Mr Booth's illness was diagnosed as terminal, but he died before it was considered.) Healthcare staff kept in touch with the hospital for updates on Mr Booth's condition.

22. While in hospital, Mr Booth was formally diagnosed with cancer of the bile duct. On 17 October, he was given a life expectancy of approximately one week and placed on end of life care. The prison appointed a family liaison officer that day. Over the next two weeks, she provided Mr Booth's partner with updates on his condition. Mr Booth had an active order confirming that he did not want to be resuscitated if his heart or breathing stopped and he asked to return to the prison to die.
23. Moorland does not provide 24-hour healthcare. Therefore, the Head of Healthcare applied to NHS England for fast track funding, to allow Mr Booth to receive nursing and end of life care at the prison. This was not approved, so she therefore explored transferring Mr Booth to another local prison who could provide this. HMP Leeds could not accept new patients as it was a COVID-19 breakout site, although they tried to create a suitable space and HMP Doncaster had no beds available. This was not resolved before Mr Booth died.
24. On 25 October, Mr Booth tested positive for COVID-19 (his previous tests in the hospital had been negative).
25. Mr Booth died in hospital on 4 November 2020. The prison arranged for him to be cremated on 12 December and met the costs.

#### **Post-mortem examination**

26. The post-mortem report concluded that Mr Booth had died from complications of cholangiocarcinoma [cancer of the bile duct]. He also had ischaemic heart disease, which did not cause but contributed to his death.
27. The report noted that Mr Booth had developed COVID-19 pneumonia in hospital, but the pathologist did not list this as one of the causes of death.

## Non-Clinical Findings

### Good practice

28. We found numerous good examples of information sharing by operational staff. Mr Booth's key worker was particularly proactive in communicating concerns to healthcare staff, as well as enabling Mr Booth to do so directly. The key worker and other wing officers made frequent and good quality entries in Mr Booth's personal record, clearly reflecting the actions taken to address his concerns and fears. While Mr Booth was in hospital, bedwatch officers copied key entries and actions from their logs and the FLO logs to his personal record, thus making the information accessible to all wing and escort staff. This enabled continuity and demonstrated genuine care about his wellbeing.
29. It is heartening that this high standard of record keeping, information sharing and engagement with Mr Booth was sustained throughout the COVID-19 pandemic, when regimes and staff resources were compromised. We commend the wing staff responsible for Mr Booth's management and recommend:

**The Governor should ensure that the Ombudsman's commendation is shared with the key worker, as well as the other wing and bedwatch staff responsible for Mr Booth's care.**

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**July 2021**



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