

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Derrick Hooley, a prisoner at HMP Moorland, on 5 September 2022**

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

## 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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Derrick Hooley died of heart failure on 5 September 2022 at HMP Moorland. He was the thirteenth prisoner to die at Moorland in three years. Mr Hooley was 76 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care Mr Hooley received at Moorland was partially equivalent to that which he could have expected to receive in the community. She makes several recommendations for healthcare to improve practice, including the creation and review of cardiovascular disease care plans when risks are identified.

The non-clinical care provided to Mr Hooley was of a good standard overall and we found no non-clinical issues of concern.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**August 2023**

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# Summary

## Events

1. On 30 April 2015, Mr Hooley was convicted for sexual offences and given an indeterminate sentence with a 12-month minimum tariff. He was transferred to HMP Leeds.
2. At Mr Hooley's initial healthcare screening, staff identified varicose eczema, asthma and acid reflux, for which he was prescribed various medications. The appropriate care plans were created to manage these conditions. Mr Hooley's basic clinical observations were within normal ranges, except for Mr Hooley's weight which was recorded as within the obese range.
3. In May 2016, routine tests showed high levels of cholesterol in Mr Hooley's blood. A prison GP prescribed medication to reduce Mr Hooley's cholesterol. Mr Hooley was also identified as at a high risk of a major coronary (heart-related) event. Healthcare created a care plan to manage the risks.
4. In 2017 and 2018 Mr Hooley attended 'NHS Health Checks', which are designed to monitor the early signs of serious illness or disease, including heart disease. No concerns were recorded and no further action was taken. In January 2018, healthcare reviewed Mr Hooley's heart health and found his risk remained high.
5. On 29 July 2020, Mr Hooley was transferred to HMP Moorland. At his initial healthcare screening, healthcare staff identified Mr Hooley's heart issues.
6. On 17 September, Mr Hooley's cholesterol levels were reviewed. Healthcare recorded that no further action was required.
7. At approximately 7.00pm on 5 September 2022, an officer completed a welfare check for Mr Hooley after a call from his wife who was concerned she had not heard from him. No concerns were raised. At approximately 2.59am, Mr Hooley's cell mate found him unresponsive and rang their cell bell. Officers attended but did not receive a response from Mr Hooley, so called a code blue emergency which triggered a request for an ambulance. Other officers a prison nurse arrived and tried to revive Mr Hooley. Paramedics arrived a short time later and pronounced Mr Hooley's death at 03:16am.

## Findings

8. The clinical reviewer concluded that the clinical care Mr Hooley received at HMP Moorland was partially equivalent to that which he could have expected to receive in the community.
9. She found issues with cardiovascular disease care planning processes for which she has made a recommendation, and several issues not relating to Mr Hooley's death.

## The Investigation Process

10. Prisons and Probation Ombudsman (PPO) Investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. She did not receive a response.
11. Another PPO Investigator took over the investigation in November 2022. The investigator obtained copies of relevant extracts from Mr Hooley's prison and medical records, and viewed Body Worn Camera footage of the emergency response.
12. NHS England commissioned a clinical reviewer to review Mr Hooley's clinical care at Moorland.
13. The investigator and clinical reviewer jointly interviewed two prison officers and two members of clinical staff on 16 February and 21 February 2023.
14. We informed HM Coroner for South Yorkshire East District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The PPO family liaison officer wrote to Mr Hooley's wife and next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. Mrs Hooley had several questions about Mr Hooley's clinical care while in HMP Moorland, which have been addressed in the clinical review. Mrs Hooley also asked to receive a copy of our report.
16. Mr Hooley's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of the report and have been addressed through separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out factual inaccuracies in the initial report and clinical review and these have been amended.

## **Background Information**

### **HMP Moorland**

18. HMP Moorland is a category C prison which holds up to 1,028 men. The Practice Plus Group provides healthcare services at the prison between 7.30am and 7.30pm five days a week, including primary care, mental health, and substance misuse services.. Outside of these hours, cover is available by telephone consultation with an emergency care practitioner or one of the local prisons' heads of healthcare on a rota system.

### **HM Inspectorate of Prisons**

19. The most recent inspection of HMP Moorland was in February 2019. Inspectors found that there had been many improvements since their previous visit in 2016. Reception screening identified individuals who needed ongoing help and advice and healthcare referrals were made appropriately. An appropriate range of primary health services and secondary care services were available.

### **Previous deaths at HMP Moorland**

20. Mr Hooley was the thirteenth prisoner to die at HMP Moorland since September 2019. Of the previous deaths, 11 were from natural causes and one was drugs related. We have previously made recommendations on the appropriate use of Cardiopulmonary Resuscitation (CPR) in emergency responses.

## Key Events

### April 2015 to July 2020

21. On 30 April 2015, Mr Hooley was convicted for sexual offences and given an indeterminate sentence with a 12-month minimum tariff. He was transferred to HMP Leeds.
22. At Mr Hooley's initial healthcare screening, staff identified varicose eczema, asthma and acid reflux, for which he was prescribed various medications. The appropriate care plans were created to manage these conditions. Mr Hooley's basic clinical observations were completed and the results were all within normal ranges, except for Mr Hooley's weight which was recorded as within the obese range.
23. On 3 May 2016, healthcare completed routine blood tests for Mr Hooley, which showed high levels of cholesterol in his blood. A prison GP recorded that Mr Hooley required statins (medication that reduces the level of cholesterol in your blood and protect the arteries). The results also showed that Mr Hooley was at a high risk for a major coronary (heart-related) event. Healthcare created a care plan to manage the risks.
24. On 9 May, a prison GP prescribed statins for Mr Hooley.
25. On 11 January 2018, Mr Hooley's coronary risk was reviewed. His risk remained high.
26. In 2017 and 2018 Mr Hooley attended 'NHS Health Checks', which are designed to monitor the early signs of serious illness or disease, including heart disease. No restraints were used on the basis of Mr Hooley's poor health. His next appointment was due for January 2023.

### HMP Moorland

27. On 29 July 2020, Mr Hooley was transferred to HMP Moorland. Healthcare staff recorded Mr Hooley's health needs, including his heart issues.
28. On 17 September, Mr Hooley's cholesterol levels were reviewed. Healthcare recorded that "no further action was required".
29. On the 2 February 2022, Mr Hooley was seen by a prison nurse, who recorded that Mr Hooley was coughing up "whitish-yellow phlegm on occasions". Mr Hooley reported that he struggled with his breathing, especially at nights. On examination the nurse noted that Mr Hooley had no shortness of breath, and he was able to walk upstairs to the HCU with the aid of a walking frame.
30. On the 8 March at 2.39pm, Mr Hooley was seen by a prison GP, who documented that he had "an increased wheeze for the last few weeks and he has a cough with some phlegm. The prison GP diagnosed Mr Hooley with a chest infection and prescribed him a course of antibiotics.

## **Events of 5 September 2022**

31. At approximately 7.00pm on 5 September, an officer completed a welfare check for Mr Hooley after a call from his wife who was concerned she had not heard from him. Mr Hooley said he had been having a “lazy day” and would call his wife shortly. The officer offered his support if Mr Hooley required it and reminded him to call his cell bell if he had any issues.
32. At approximately 2.59am hours, Mr Hooley’s cell mate found Mr Hooley unresponsive and rang their cell bell. An officer responded and attended the cell. The officer called to Mr Hooley but did not receive a response, so called a code blue emergency, which triggered a request for an ambulance. Other officers and a prison nurse arrived soon after. They laid Mr Hooley on the floor and used cardiopulmonary resuscitation (CPR) and a defibrillator to revive Mr Hooley. Paramedics arrived and took over. They pronounced Mr Hooley’s death at 03:16am hours.

## **Contact with Mr Hooley’s family**

33. On the 6 September, the prison family liaison officer (FLO) and a governor visited Mrs Hooley at her home address to inform her that Mr Hooley had died and offer support.
34. Moorland offered a contribution to Mr Hooley’s cremation, in line with national policy.

## **Support for prisoners and staff**

35. After Mr Hooley’s death, healthcare and prison managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Mr Hooley’s death and offering support in case they had been adversely affected.

## **Post-mortem report**

37. The post-mortem report concluded that Mr Hooley died of acute myocardial ischaemia (when blood flow to the heart is reduced, preventing the heart muscle from receiving enough oxygen) caused by ischaemic heart disease (where the blood vessels supplying the heart are narrowed or blocked) and severe coronary artery atheroma (where fatty material builds up inside the arteries). Hypertension (high blood pressure) was listed as a contributing factor.

## Findings

38. The clinical reviewer found that the clinical care provided to Mr Hooley was partially equivalent to that which he could have expected to receive in the community.
39. She made a number of recommendations to improve healthcare practice at Moorland, including the need for care plans where cardiovascular disease is an identified risk and the appropriate use of cardiopulmonary resuscitation (CPR). These recommendations should be addressed by the Head of Healthcare.
40. We found that the non-clinical care provided to Mr Hooley was of a good standard overall. We did not identify any significant learning.

## Inquest

41. The inquest into Mr Hooley's death concluded on the 17 August 2023. The coroner confirmed that Mr Hooley died of natural causes.

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