Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr David Moyle, a prisoner at HMP Littlehey, on 28 August 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

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. In January 2019, Mr David Moyle was sentenced to twelve years in prison for sexual offences. He died of pneumonia on 28 August 2024 in hospital, while a prisoner at HMP Littlehey. He was 81 years old. We offer our condolences to those who knew him.

4. The Ombudsman office did not contact Mr Moyle's next of kin at their request.

5. NHS England commissioned an independent clinical reviewer, to review Mr Moyle's clinical care at Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Moyle received at Littlehey was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. He found that healthcare staff appropriately responded when Mr Moyle's health deteriorated. The clinical reviewer made recommendations which were not related to Mr Moyle's death but which the Head of Healthcare will want to address.

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

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Northamptonshire Healthcare NHS Foundation Trust pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

10. At an inquest held on 11 June 2025, the Coroner concluded that Mr Moyle died of natural causes.

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

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