Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Coe, a prisoner at HMP Moorland, on 22 March 2025

A report by the Prisons and Probation Ombudsman

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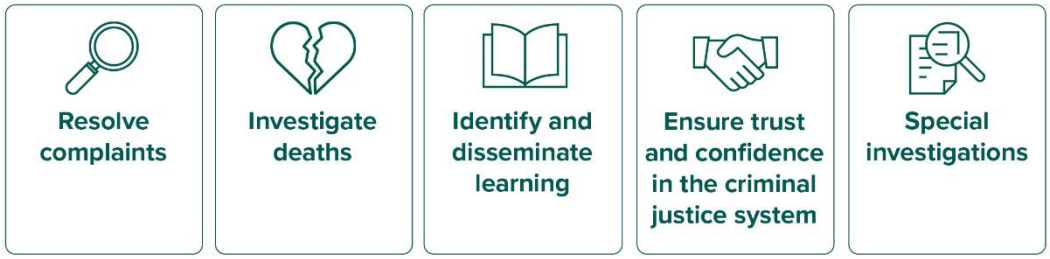
OUR VISION

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 October 2023, Mr Dennis Coe was sentenced to seven years in prison for sex offences. He died of respiratory failure caused by a chest infection, in hospital, on 22 March 2025, while a prisoner at HMP Moorland. A prolonged air leak from his lung, which developed after recent chest surgery for lung cancer, also contributed to his death. He was 75 years old. We offer our condolences to Mr Coe's family and friends.

4. The Ombudsman's office wrote to Mr Coe's next of kin, his niece, and his daughter to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Coe's clinical care at HMP Moorland.

6. The clinical reviewer concluded that the clinical care Mr Coe received at Moorland was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Coe had a care coordinator who worked closely with a multidisciplinary team, including social care, healthcare staff, and physiotherapists. She noted effective joint working by the team, with regular, timely and responsive reviews and weekly meetings to discuss his care. The clinical reviewer also noted that healthcare staff regularly monitored and recorded Mr Coe's weight and prescribed nutritional support drinks to ensure he received adequate nutrition. She found evidence in the medical records that healthcare and prison staff treated Mr Coe respectfully and compassionately throughout his care. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Coe's care. We did not find any non-clinical issues of concern. We make no recommendations.

Good Practice

8. The family liaison officers demonstrated efforts that went above and beyond in their compassion and support offered to Mr Coe's family, which was commendable.

9. The initial report was shared with HM Prison and Probation Service (HMPPS) and the prison's healthcare provider, Practice Plus Group. Practice Plus Group pointed out a factual inaccuracy within the clinical review report which has been amended accordingly.

10. Mr Coe's family received a copy of the draft report. They did not make any comments.

Inquest

11. The inquest hearing was held on 4 April 2025. The Coroner concluded that Mr Coe died of natural causes.

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

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