Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hines, a prisoner at HMP Hewell, on 25 October 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

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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 September 2024, Mr Peter Hines was sentenced to 27 months for burglary. He died of cardiac amyloidosis on 25 October 2024, in hospital while a prisoner at HMP Hewell. He was 65 years old. We offer our condolences to Mr Hines' family and friends.

4. The Ombudsman's office wrote to Mr Hines' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Hines' family asked about the checks staff completed on Mr Hines, and whether his missed hospital appointments affected his health negatively. These concerns have been addressed in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Hines' clinical care at HMP Hewell.

6. The clinical reviewer concluded that the clinical care Mr Hines received at Hewell was of a good standard and equivalent to what he could have expected to receive in the community. She found that despite healthcare staff offering unified support to Mr Hines on several occasions, he would not engage. The clinical reviewer made recommendations not related to Mr Hines' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Hines's care. We did not find any non-clinical issues of concern.

8. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS/Practice Plus Group pointed out some factual inaccuracies, and this report has been amended accordingly.

10. Mr Hines family received a copy of the initial report. They did not make any comments.

Adrian Usher **May 2025**
Prison and Probation Ombudsman

At the inquest held on 2 June 2025, the coroner concluded Mr Peter Hines died from natural causes.

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