

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Williams, a prisoner at HMP Littlehey, on 3 August 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



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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. 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. Mr Peter Williams died of metastatic urothelial carcinoma of the bladder (advanced bladder cancer) on 3 August 2025, while a prisoner at HMP Littlehey. He was 67 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care Mr Williams received at Littlehey was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She deemed that Mr Williams was managed with compassion and care during his time in Littlehey. However, the clinical reviewer also found that there was no evidence that Mr Williams was discussed in a Palliative Care Team multi-disciplinary meeting, in line with the Littlehey Palliative Care Protocol. She concluded that this was a missed opportunity to discuss Mr Williams' medication needs and deteriorating presentation with the social care team.
5. The decision to apply restraints to Mr Williams when he was taken to hospital on 12 May, and to leave him in restraints until the following day, was not justified given his age, poor mobility and poor health.

Recommendations

- The Head of Healthcare should ensure that patients presenting with complex health needs, including those receiving palliative care, are discussed in a multi-disciplinary meeting.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, including that:
 - Managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time.
 - A robust quality assurance process is implemented to check that these measures are in place and effective.

The Investigation Process

6. HMPPS notified us of Mr Williams' death on 3 August 2025.
7. NHS England commissioned an independent clinical reviewer, to review Mr Williams' clinical care at HMP Littlehey.
8. The PPO investigator investigated the non-clinical issues relating to Mr Williams' care.
9. The Ombudsman's office wrote to Mr Williams' sister, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Williams' sister did not raise any matters for consideration but requested a copy of our report.
10. We shared the initial report with HM Prison and Probation Service (HMPPS) and Northamptonshire Healthcare NHS Foundation Trust. HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report. Northamptonshire Healthcare NHS Foundation Trust pointed out one factual inaccuracy in the clinical review, which we shared with the clinical reviewer.
11. We also shared the initial report with Mr Williams' sister. She did not make any comments.

Previous deaths at HMP Littlehey

12. Mr Williams was the 43rd prisoner to die at Littlehey since August 2022. Of the previous deaths, 38 were from natural causes, three were self-inflicted, and one is awaiting classification. To the end of November 2025, two more prisoners have died from natural causes.
13. Our investigation into the death of a man in May 2024 found that the questions in the medical section of the escort risk assessment had been misinterpreted and the responses contradicted the use of restraints. In January 2025, we recommended that the Head of Healthcare ensure that staff involved in the escort decision-making process receive training on the policy framework and legal position relating to hospital escorts, taking a prisoner's current medical condition and how this impacts their ability to escape into consideration.
14. In response to our recommendation, Littlehey said that they would produce a standard operating procedure to give guidance to all staff involved in the escort decision making process. They said that this would look at the prisoner's medical condition and how this impacts their ability to escape in line with the Graham judgement.

Key Events

15. In August 2010, Mr Peter Williams was sentenced to Imprisonment for Public Protection with a minimum term of three years, for a sexual offence.
16. In June 2019, Mr Williams was diagnosed with prostate cancer. On 25 March 2022, he transferred to HMP Littlehey.
17. Despite undergoing surgery and chemotherapy, Mr Williams' cancer progressed, and in May 2025 it was deemed that chemotherapy was no longer effective.
18. On 12 May 2025, palliative care team staff at Littlehey visited Mr Williams. He reported feeling unwell and had passed urine which was heavily blood stained. Following a discussion with the hospital Oncology team, it was agreed to send Mr Williams to hospital.
19. Staff completed a person escort record (PER) and escort risk assessment. A nurse at Littlehey completed the medical section of the PER and recorded that Mr Williams had poor mobility and required support with his personal care, mobility or hygiene needs. She also completed the medical information section on the escort risk assessment and wrote that there was a medical objection to the use of restraints. She wrote that a nurse at Littlehey and the hospital consultant had said that Mr Williams' reduced physical mobility affected the use of standard cuffs and an escort chain should be used instead. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist.) The nurse also said that Mr Williams may need a wheelchair for long distances, that he had cancer and was very unwell and frail, and that his health and mobility affected his ability to escape. The security assessment noted that Mr Williams' risk of escape and risk to the public were normal.
20. The authorising manager signed the risk assessment and recorded that they had considered the healthcare risk assessment. They said they were aware that there was a medical objection to the use of restraints and wrote that an escort chain should be used due to mobility issues.
21. On 12 May, Mr Williams was escorted to hospital by two prison officers who applied an escort chain. The risk assessment paperwork said that Mr Williams complained about the cuffs being too tight. (There is no evidence that anyone considered this further or adjusted the handcuffs.)
22. At approximately 1.20pm on 13 May, prison staff removed the escort chain due to Mr Williams' poor mobility and health. Mr Williams returned to Littlehey on 17 May. This was the last time he went to hospital.
23. In June, due to Mr Williams' deteriorating health, Littlehey appointed a family liaison officer, who contacted Mr Williams' sister and kept her updated about his condition.
24. Mr Williams' health continued to decline and, on 3 August, Mr Williams died in his cell in Littlehey. The family liaison officer phoned Mr Williams' sister to inform her of his death, as they had previously agreed.

Cause of death

25. The Coroner accepted the cause of death provided by a consultant working at Littlehey and no post-mortem examination was carried out. The consultant gave the cause of death as metastatic urothelial carcinoma of the bladder (advanced bladder cancer).

Inquest

26. At the inquest held on 23 March 2026, the Coroner concluded that Mr Williams died from natural causes.

Findings

Clinical findings

27. The clinical reviewer concluded that the clinical care Mr Williams received at Littlehey was of a reasonable standard and was equivalent to that which he could expect to receive in the community. She found that Mr Williams was managed with compassion and care during his time in Littlehey. However, the clinical reviewer also found that there was no evidence that Mr Williams was discussed in a Palliative Care Team multi-disciplinary meeting, in line with the Littlehey Palliative Care Protocol. She concluded that this was a missed opportunity to discuss Mr Williams' medication needs and deteriorating presentation with the social care team.
28. We make the following recommendation:
- The Head of Healthcare should ensure that patients presenting with complex health needs, including those receiving palliative care, are discussed in a multi-disciplinary meeting.**
29. The clinical reviewer made a further recommendation about matters not directly related to Mr Williams' death but which the Head of Healthcare will want to address.

Use of restraints

30. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
31. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The Prevention of Escape: External Escorts policy framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and ill health. The policy framework also states that escort chains should not be used as a less secure form of restraint.
32. Healthcare staff recorded a medical objection to the use of restraints, due to Mr Williams' poor health and mobility. They highlighted his diagnosis, that he was frail and that he required a wheelchair for longer distance. However, they also noted that an escort chain was recommended, seemingly on the advice of a nurse and hospital consultant. The authorising manager decided to use an escort chain because of Mr Williams' mobility. The healthcare advice and subsequent decision to use an escort chain is not in line with the requirements of the policy framework.

33. We consider that restraints should not have been applied to Mr Williams when he was taken to hospital on 12 May. He was 67 years old, had a terminal cancer diagnosis and poor mobility, and healthcare staff had objected to the use of restraints. We can see no justification for using restraints on Mr Williams, given his health needs and the associated negligible risk of escape. While healthcare staff recognised and recorded Mr Williams' poor health, they should not have recommended use of an escort chain and this should not have been used as a reduced form of restraint. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, including that:

- **Managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time.**
- **A robust quality assurance process is implemented to check that these measures are in place and effective.**

**Adrian Usher
Prisons and Probation Ombudsman**

May 2026

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