Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrence Hulme, a prisoner at HMP Parc, on 20 September 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 October 2023, Mr Terrence Hulme was sentenced to 18 years in prison for sexual offences. He died of central nervous system lymphoma (a rare type of cancer that starts in the lymphatic cells of the brain or spinal cord), in hospital, on 20 September 2024, while a prisoner at HMP Parc. Ischaemic heart disease (a condition which causes reduced blood supply to the heart muscle due to blocked or narrowed arteries) also contributed to his death. Mr Hulme was 88 years old. We offer our condolences to Mr Hulme's family and friends.

4. The Ombudsman's office wrote to Mr Hulme's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked a question regarding the timeframe for Mr Hulme's arrival at the hospital, which has been addressed in separate correspondence.

5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr Hulme's clinical care at Parc.

6. The clinical reviewer concluded that the clinical care Mr Hulme received at Parc was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that Mr Hulme had access to a range of health services, including occupational health, physiotherapy and speech and language therapy. He noted that Mr Hulme received appropriate care, including dietary support, falls risk assessments, and comprehensive management of his diabetes. The clinical reviewer also found that there was consistent communication between prison healthcare staff and hospital staff during Mr Hulme's hospital admission. The clinical reviewer made eight recommendations, which did not impact on his assessment of equivalence, that the Head of Healthcare will wish to address.

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

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy within the clinical review report which has been amended accordingly.

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

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

Inquest

At the inquest held on 4 December 2025, the Coroner concluded that Mr Hulme died from natural causes.

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