

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Peter Tillotson a prisoner at HMP Wakefield on 23 July 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Peter Tillotson, who was 61 years old, died of lung cancer on 23 July 2019 at HMP Wakefield. We offer our condolences to Mr Tillotson's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Tillotson received was equivalent to that which he could have expected to receive in the community. However, she made two recommendations.
5. The investigator found that there were delays processing Mr Tillotson's request for early release on compassionate grounds and that no one seemed to have overall responsibility for its progress.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendations

- The Head of Healthcare should ensure that staff are aware of the need to appropriately escalate any clinical concerns.
- The Head of Healthcare should ensure that staff consider transferring patients to the inpatient facility if they assess that there is a clinical need.
- The Governor and the Head of Healthcare should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Tillotson's clinical care at HMP Wakefield. The clinical review is attached to this report as Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Tillotson's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Our investigator wrote to Mr Tillotson's next of kin, his sister, to explain the investigation. She did not raise any specific issues.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at Wakefield

10. Mr Tillotson was the 19th person to die at HMP Wakefield since June 2017. Of the previous deaths, sixteen were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation of Mr Tillotson's death and the other deaths.

## Key Events

11. On 20 September 2017, Mr Peter Tillotson was sentenced to 22 years in prison for sexual offences. He was moved to HMP Wakefield on 20 October 2017.
12. At around 11.30pm on 25 January, a nurse went to see Mr Tillotson because he was complaining of abdominal pain. The nurse took Mr Tillotson's clinical observations and then contacted an out of hours GP, who did not feel it was necessary to attend himself but advised that Mr Tillotson should go to hospital for further investigations. The duty governor, said that as it was not a life-threatening situation, he could not arrange a transfer to hospital that night. Staff made Mr Tillotson comfortable and observed him overnight.
13. The next day, staff reviewed Mr Tillotson, who reported mild abdominal discomfort. They did not send him to hospital. His condition remained relatively stable for the next two weeks. On 13 February, a prison GP saw Mr Tillotson, who said his abdominal pain had got much worse. The prison GP sent him to hospital for investigations.
14. Mr Tillotson was diagnosed with lung cancer in March. Hospital doctors considered that he was not suitable for surgery or chemotherapy and that his condition was terminal. Palliative radiotherapy (to control the cancer rather than cure it) was initially considered an option, but Mr Tillotson became too unwell to undergo treatment.
15. In May, Mr Tillotson asked to be released from prison on compassionate grounds. The application was not completed before Mr Tillotson died.
16. On the evening of 23 July, a nurse recorded that she sat with Mr Tillotson in the palliative care suite when he died. In line with his wishes, healthcare staff did not try to resuscitate him. At 8.10pm, an ambulance paramedic pronounced Mr Tillotson dead.
17. There was no post-mortem examination as the Coroner accepted the cause of death provided by a hospital consultant. The consultant gave Mr Tillotson's cause of death as lung cancer.

## Findings

18. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 [or PSO 4700 for prisoners serving indeterminate sentences]. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prisons and Probation Service (HMPPS).
19. On 20 May 2019, a Matron contacted Wakefield's Offender Management Unit (OMU) and requested an early release on compassionate grounds application pack, which was sent to her the same day.
20. On 21 May, a Lifer Clerk emailed a copy of the offender manager's section of the form to the offender supervisor, who said he would pass it on to Mr Tillotson's offender manager. The OMU Manager was unable to tell the investigator what happened with that part of the application.
21. On 22 May, a Matron emailed a copy of the form's completed medical section to the Governor's secretary when she had in fact meant to send it to the Lifer Clerk. The medical section said that Mr Tillotson had approximately a month to live. The Matron did not hear back.
22. The Governor's secretary told the investigator that she was on leave at the time the Matron sent the email and other people had monitored her inbox. On 1 July, the Matron emailed the medical section of the form to the Governor's secretary again. On 3 July, the Governor's secretary replied and asked the Matron if she had meant to send the form to someone else but did not hear back. The Matron was unable to recall if she had ever seen that email and nothing further happened with the application.
23. We are concerned that despite staff starting a compassionate release application for Mr Tillotson, it was never completed. After 1 July, no one took any action on the application and it was not submitted before Mr Tillotson died. We accept that human errors (such as the email mistake) do happen but consider that if a single individual had had responsibility for the application process the delays may have been noticed and investigated sooner. We make the following recommendation:

**The Governor and the Head of Healthcare should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.**

