

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hale, a prisoner at HMP Wayland, on 20 August 2022

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 Hale died in hospital of lung cancer on 20 August 2022, while a prisoner at HMP Wayland. He was 67 years old. We offer our condolences to Mr Hale's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Hale received at Wayland was equivalent to that which he could have expected to receive in the community.
5. Mr Hale was taken to hospital on 1 August with a suspected stroke, after he was found collapsed in his cell. We found that the escort risk assessment did not contain any information about Mr Hale's state of health and mobility, as the medical section of the form did not ask for this information. We are concerned that the manager who authorised the use of restraints did not have sufficient information about Mr Hale's medical condition to decide whether use of restraints was proportionate to his risk.

Recommendations

- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
 - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
 - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hale's clinical care at Wayland.
7. The PPO investigator investigated the non-clinical issues relating to Mr Hale's care, including his cell location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Hale's sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Wayland

10. Mr Hale was the sixth prisoner to die at Wayland since August 2020. Of the previous deaths, four were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Hale's death and our findings from the previous deaths.

Key Events

11. In December 1978, Mr Peter Hale was convicted of murder and sentenced to life imprisonment.
12. On 6 February 2020, Mr Hale was moved to HMP Wayland.
13. On 17 July 2022, a prison officer asked a nurse to see Mr Hale as he said he felt dizzy. A nurse saw Mr Hale and completed clinical observations, all of which were within normal range. The nurse referred Mr Hale to the prison GP.
14. On 18 July, the prison GP saw Mr Hale. He said he had dizziness, headaches and had lost weight over the last few months. He also said he had fallen and hit his head approximately five months ago. The prison GP requested a CT scan for Mr Hale.
15. On 1 August, prison staff asked healthcare staff to see Mr Hale in his cell. He was on the floor and had soiled himself. A nurse completed observations on Mr Hale and was concerned Mr Hale may have had a stroke. The nurse requested an ambulance. Paramedics arrived later that day and took Mr Hale to hospital, where he was admitted.
16. On 2 August, the hospital completed a CT scan on Mr Hale and found growths on his brain, which they suspected to be cancer. Mr Hale remained in hospital for further investigations. Prison healthcare staff contacted the hospital daily for updates.
17. On 16 August, a healthcare administrative assistant called the hospital for an update. She was told Mr Hale had lung cancer, which had spread to his brain and liver.
18. On 19 August, a healthcare assistant called the hospital for an update. She was told that Mr Hale was not suitable for treatment and had weeks to months left to live.
19. Mr Hale's condition quickly deteriorated and on 20 August at 2.04pm, he died in hospital.

Cause of death

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Hale's cause of death as metastatic lung cancer (cancer that has spread).

Non-Clinical Findings

Restraints, security and escorts

21. 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. 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.
22. We are concerned that the escort risk assessment for Mr Hale's hospital admission on 1 August did not contain any information about his state of health, including that a stroke was suspected. While the medical section of the escort risk assessment form had been completed, it did not ask whether the prisoner had any medical conditions that might affect their ability to escape or provide a space for healthcare staff to say whether the prisoner was in poor health or had poor mobility.
23. Authorising managers must have information about the prisoner's current state of health and mobility so that they can decide whether the use of restraints is proportionate to a prisoner's risk. We recommend:

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

Louise Richards
Assistant Ombudsman

December 2022

Inquest conclusion

24. The inquest, heard on 13 February 2023, concluded that Mr Hale died from natural causes.

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