Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Taklus Hussain, a prisoner at HMP Littlehey, on 8 March 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

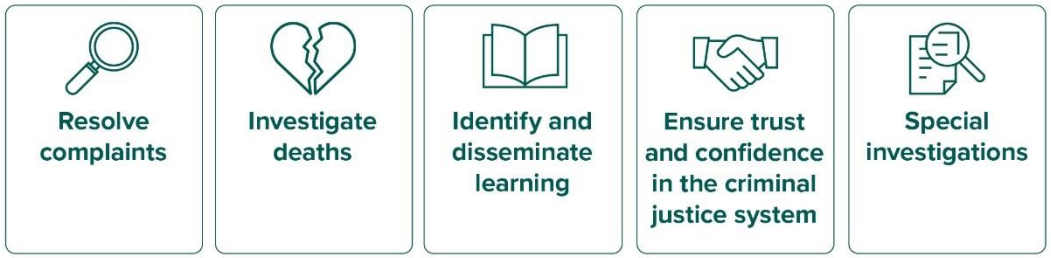
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 Taklus Hussain died in hospital of pneumonia (infection of the lungs) on 8 March 2024, while a prisoner at HMP Littlehey. He was 70 years old. We offer our condolences to Mr Hussain's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hussain received at Littlehey was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found that the decision to restrain Mr Hussain when he was taken to hospital was not justified given his poor mobility.

Recommendations

- The Operational Security Group Director at HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient and outpatient appointments), including at HMP Littlehey, and discuss the findings with the Ombudsman.

The Investigation Process

6. HMPPS notified us of Mr Taklus Hussain's death on 8 March 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Hussain's clinical care at Littlehey.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hussain's care.

9. The Ombudsman's office wrote to Mr Hussain's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not raise any questions.

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

Previous deaths at HMP Littlehey

10. Mr Hussain was the 41st prisoner to die at Littlehey since 8 March 2021. Of the previous deaths, 36 were from natural causes and four were self-inflicted. Up to the end of July, four prisoners have died of natural causes since Mr Hussain's death.

11. We have previously made recommendations about compliance with the use of restraints policy. In investigations into the deaths of two prisoners at Littlehey in 2022, the Governor and Head of Healthcare accepted recommendations that prison managers should consider the health of a prisoner when making decisions on the use of restraints. Following a death in August 2023, we made a further recommendation regarding the inappropriate use of restraints.

Key Events

11. On 13 July 2018, Mr Hussain was sentenced to 20 years imprisonment for historic sex offences. On 15 October 2021, he transferred to HMP Littlehey.

12. Mr Hussain had a history of high blood pressure, angina (attacks of chest pain), Chronic Obstructive Airway Disease (lung disease that causes breathing problems), and Ischaemic Heart Disease (blood vessels supplying the heart are narrowed or blocked).

13. After Mr Hussain's transfer to Littlehey, he was diagnosed with Interstitial Lung Disease (a chronic disease that makes it hard for the lungs to get enough oxygen). Mr Hussain's condition worsened significantly in August 2022. He attended regular appointments with prison healthcare and hospital staff.

14. On 11 January 2024, Mr Hussain attended healthcare for a review appointment as he had a cough that was not improving. He was diagnosed with a chest infection and prescribed antibiotics to treat this.

15. On 22 January, Mr Hussain was seen by a nurse and informed her that he did not wish to take the prescribed antibiotics, despite her explanation of their benefits. On 24 January, he felt dizzy and when the nurse assessed him, Mr Hussain confirmed he was not taking his medication. His condition worsened that day when the levels of oxygen in his blood lowered, and he was transferred to hospital. Mr Hussain received oxygen therapy.

16. On 8 February, Mr Hussain returned to Littlehey where his condition continued to be monitored by healthcare staff.

17. On 12 February, Mr Hussain relocated to a different cell on a ground floor landing due to his mobility and breathing problems. He was able to walk on his own with some difficulty, but he used a wheelchair for longer distances.

18. Towards the end of February and beginning of March, Mr Hussain began to feel increasingly unwell. He had a cough, felt dizzy and achy. On 3 March, he was finding it difficult to get out of his wheelchair, was on permanent oxygen and a nurse noted that he looked tired and pale.

19. Mr Hussain was admitted to hospital for assessment that day. Healthcare staff contributed to the restraints risk assessment and recorded that Mr Hussain was 70 years old, used a wheelchair and required oxygen. Security staff decided that Mr Hussain should be escorted by two officers and restrained by an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Mr Hussain was discharged the same day.

20. On 6 March, Mr Hussain's condition worsened. He said his chest was hurting, he was coughing, he could not get to the bathroom so had urinated on the floor and was confused. A nurse assessed him, and he had a National Early Warning Score (NEWS2 – used to identify acutely ill patients) of nine. A score of seven or more means that there is a high clinical risk, and the patient needs an urgent or emergency response. The nurse told us that Mr Hussain needed increased oxygen, was short of breath, had a high temperature, and a worsening chest infection. His

mobility had also reduced further, and he was unable to transfer to his wheelchair independently.

21. Staff requested an ambulance via 999 and paramedics took Mr Hussain to hospital. A nurse completed the medical section of the risk assessment and noted that Mr Hussain's health and mobility did not affect his ability to escape, but also noted that he was a wheelchair user. She did not record any objections to the use of restraints. The security team completed the risk assessment and Mr Hussain was again escorted by two officers and restrained by an escort chain. Mr Hussain was admitted to hospital, diagnosed with heart failure, and was treated on the end-of-life pathway.

22. On 7 March, healthcare staff were told that Mr Hussain was being treated with antibiotics for pneumonia.

23. Mr Hussain signed a Do Not Resuscitate Order (DNACPR) to express his wish not to be resuscitated if his heart or breathing stopped. This document was on file at the time of death and had been signed on 5 March, but it is unclear when discussions about this with Mr Hussain took place.

24. On 8 March, Mr Hussain went into cardiac arrest. Hospital staff did not attempt to resuscitate him, as per the DNACPR and he died.

Post-mortem report

25. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor determined that Mr Hussain died of pneumonia. COPD and interstitial lung disease also contributed to, but did not cause, his death.

Non-Clinical Findings

Restraints, security and escorts

26. 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.

27. On 3 March, healthcare staff contributed to the escort risk assessment and concluded that Mr Hussain's health conditions affected his ability to escape. Mr Hussain was restrained by an escort chain. Three days later, when his health had deteriorated further, healthcare staff did not record any concerns about the use of restraints, and he was again restrained with an escort chain. Mr Hussain was 70 years old, a wheelchair user reliant on oxygen and in poor health.

28. In interview, a nurse explained that although Mr Hussain was very poorly, she did not have time to reflect the details of his health concerns on the risk assessment form, due to the urgency of the situation.

29. The Head of Security authorised Mr Hussain to be restrained by an escort chain and escorted by two officers. She said that there was no time to get further information from healthcare staff and, as far as she was aware at the time, Mr Hussain was conscious, not critically ill, and able to walk. She explained that if she had been aware of the extent of Mr Hussain's health condition, she would have probably decided not to authorise restraints.

30. A senior manager authorised the decision to remove Mr Hussain's restraints early the next morning due to the deterioration in Mr Hussain's condition and his reduced mobility. We welcome this decision. However, we consider that the decisions to restrain him on 3 and 6 March were inappropriate given his health conditions, age, frailty and limited mobility.

31. We have previously made recommendations regarding the inappropriate use of restraints at Littlehey in 2022 and 2023. It is therefore disappointing that Mr Hussain was restrained.

The Operational Security Group Director at HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient and outpatient appointments), including at HMP Littlehey, and discuss the findings with the Ombudsman.

The Head of Healthcare should ensure that healthcare staff accurately complete the medical information section of the escort risk assessment in full.

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

Inquest

The inquest hearing was held on 2 December 2024. The Coroner concluded that Mr Hussain died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100