Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stewart Hirst, a prisoner at HMP Littlehey, on 16 July 2023

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

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 Stewart Hirst died in a hospice of lung cancer on 16 July 2023, while a prisoner at HMP Littlehey. He was 42 years old. We offer our condolences to Mr Hirst's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hirst received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made several recommendations not related to Mr Hirst's death which the Head of Healthcare will wish to address.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Hirst's death on 16 July 2023.

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

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

9. The PPO family liaison officer wrote to Mr Hirst's father to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. We shared our initial report with HMPPS. They found no factual inaccuracies.

Previous deaths at HMP Littlehey

11. Mr Hirst was the forty-fourth prisoner to die at Littlehey since July 2020. Of the previous deaths, 39 were from natural causes and four were self-inflicted.

Key Events

12. On 20 September 2018, Mr Stewart Hirst was sentenced to eight years imprisonment for sexual offences. He was released on licence on 3 December 2021.

13. On 13 January 2023, Mr Hirst was recalled to prison for breach of his licence conditions. He was taken to HMP Lewes.

14. On 27 February, the healthcare team at Lewes placed Mr Hirst on a medical hold (which meant he was not to be transferred to another prison) as a chest X-ray showed he had a mass on his lung that might be cancer. Mr Hirst needed further tests to confirm his diagnosis.

15. On 6 March, Mr Hirst had a CT scan. He was waiting for hospital doctors to have a multidisciplinary team (MDT) meeting to find out the results.

16. Mr Hirst asked to transfer to HMP Littlehey while on a medical hold as he wanted to start an alcohol recovery course. A nurse at Lewes advised him not to transfer as he was still awaiting the results of his CT scan. He told her that still wanted the transfer to go ahead and did not want to delay this.

17. On 7 March, Mr Hirst was moved to Littlehey.

18. On 20 March, a palliative care consultant and nurse at Littlehey told Mr Hirst that his CT scan results showed that it was likely he had lung cancer. They told him that he would need to go to the hospital for a biopsy and further scans before finding out what treatment he could have. The palliative care consultant made an urgent two-week referral to the hospital for suspected cancer.

19. On 26 April, the palliative care consultant spoke to the hospital to find out why Mr Hirst had not received a hospital appointment yet. She was told that they could not find the referral for Mr Hirst on their system, despite the form being sent. She sent a second referral the same day.

20. On 11 May, a hospital respiratory consultant told Mr Hirst that his CT scan showed he had lung cancer. He referred him to the lung multidisciplinary team (MDT) who would review his scan results and decide on treatment.

21. On 16 May, a GP at Littlehey saw Mr Hirst as he was in pain from swelling in his knee and ankle. The GP started him on water tablets to reduce the swelling and gave him some strong pain relief.

22. On 5 June, the palliative care consultant saw Mr Hirst. He told her he was struggling to walk due to severe pain in his lower back, right arm, and legs. She examined his chest and was concerned that Mr Hirst had fluid on his lung. She arranged for him to be admitted to hospital for further assessment.

23. The next day, the palliative care consultant saw Mr Hirst as he had discharged himself from hospital. She urged him to go back to hospital as he was seriously unwell and needed specialist care, but he insisted that did not want to go. Mr Hirst agreed that he would instead go to a hospice where they could manage his pain

better (as Littlehey did not have 24-hour healthcare). He told her that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

24. On 7 June, Mr Hirst was transferred to a hospice for palliative care.

25. On 12 June, Mr Hirst was taken to hospital as he had severe back pain. An oncologist (cancer doctor) told him that his cancer had spread to his bones, kidney and liver and could not be treated. He was started on palliative care and had a likely prognosis of six months.

26. On 19 June, Mr Hirst was discharged back to the hospice for palliative care.

27. On 5 July, staff at Littlehey submitted an application for Mr Hirst's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of HMPPS. A decision had not been made before Mr Hirst died.

28. On 11 July, Mr Hirst's health deteriorated, and the hospice placed him on an end-of-life care plan. A nurse at Littlehey spoke to the hospice and was told that Mr Hirst was in his final days of life.

29. On 16 July at 11.50am, Mr Hirst died.

Cause of death

30. The coroner accepted the cause of death provided by the hospice doctor and no post-mortem examination was carried out. The doctor gave Mr Hirst's cause of death as advanced metastatic lung cancer.

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

Inquest

The inquest, held on 16 December 2024, concluded that Mr Hirst died from natural causes.

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