Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Littlewood, a prisoner at HMP/YOI Moorland Closed, on 25 August 2023

A report by the Prisons and Probation Ombudsman

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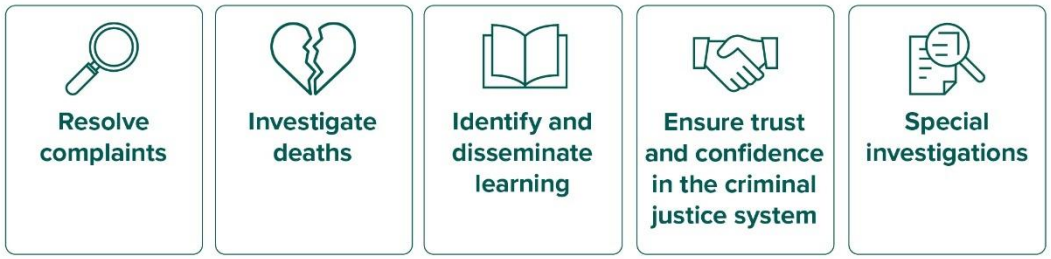
OUR VISION

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

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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.

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.

Mr Richard Littlewood died of methadone toxicity on 25 August 2023 at HMP/YOI Moorland. He was 43 years old. I offer my condolences to Mr Littlewood's family and friends.

Mr Littlewood had a history of using illicit substances and was prescribed methadone in prison. The clinical reviewer found that he received appropriate support from the substance misuse service. However, his substance misuse service care manager and support worker were not always appropriately involved when Mr Littlewood's methadone dose was increased and he was not consistently monitored for signs of over sedation or toxicity.

The investigation found no evidence that Mr Littlewood was at risk of suicide and self-harm and that he intended to overdose.

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

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

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Summary

Events

1. Mr Richard Littlewood was released from prison on licence in October 2022, having served 10 months for theft, using threatening words or behaviour and causing damage to property. In January 2023, he was recalled to prison and transferred to HMP/YOI Moorland on 8 March.

2. Mr Littlewood had a history of substance and alcohol misuse and was prescribed methadone in the community.

3. A GP at the prison prescribed Mr Littlewood 50mls of methadone (an opiate prescribed as a substitute for heroin) a day. The substance misuse service (SMS) saw Mr Littlewood regularly.

4. In April 2023, Mr Littlewood asked for an increase to his methadone dose because he was experiencing withdrawal symptoms. A GP at the prison prescribed 60mls of methadone a day.

5. Mr Littlewood continued to complain of withdrawal symptoms and the GP increased his daily methadone dose to 75mls on 3 July, and 90mls on 9 August.

6. At around 8.10pm on 24 August, a member of staff locked Mr Littlewood in his cell. They did not notice anything unusual.

7. At 5.25am on 25 August, the same member of staff completed a routine check and found Mr Littlewood unresponsive on the cell floor. They radioed a medical emergency code and staff responded quickly. Staff started cardiopulmonary resuscitation (CPR). Paramedics arrived at 5.40am and at 5.55am, confirmed that Mr Littlewood had died.

8. The post-mortem examination established that Mr Littlewood died from methadone toxicity.

Findings

9. The clinical reviewer found that some aspects of Mr Littlewood's clinical care were equivalent to what he could have expected to receive in the community. However, she was concerned that health screens were not completed in accordance with guidance and health care staff did not review Mr Littlewood after he reported suffering a seizure.

10. Mr Littlewood received appropriate support from the substance misuse service. However, the substance misuse service prescriber increased Mr Littlewood's methadone dose without consulting his substance misuse service care manager or support worker and they were not always appropriately involved in the prescribing decisions.

11. When Mr Littlewood's methadone dose was increased, healthcare staff did not routinely record his clinical opiate withdrawal scale (COWS - used to monitor the

symptoms and signs of opiate withdrawal) score or consistently monitor him for signs of over-sedation or toxicity.

12. There was no evidence that Mr Littlewood was at risk of suicide and self-harm or that he intentionally took more methadone than he was prescribed.

Recommendation

13. The Head of Healthcare at HMP/YOI Moorland should ensure that following an increase in a patient's methadone dose, healthcare staff follow the Department of Health's guidance on the clinical management of drug misuse and dependence.

The Investigation Process

14. HMPPS notified us of Mr Littlewood's death on 29 August 2023.

15. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Littlewood's prison and medical records, viewed CCTV and body worn video camera (BWVC) footage, and listened to recordings of radio transmissions and Mr Littlewood's prison telephone calls.

17. NHS England commissioned a clinical reviewer to review Mr Littlewood's clinical care at the prison.

18. The investigator and clinical reviewer interviewed five members of healthcare staff at Moorland between July and September 2023.

19. We informed HM Coroner for Yorkshire South East of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office wrote to Mr Littlewood's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

21. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

22. NHS England rejected the recommendation. The Commissioner said that the healthcare provider, Practice Plus Group, has completed a review and audit of the prescriber's decision making in partnership with the Regional SMS lead. The review concluded that the prescriber reviewed and amended Mr Littlewood's methadone prescription in line with national guidance. An audit of the prescriber's decisions with other patients did not identify any concerns.

Background Information

HMP/YOI Moorland

23. HMP/YOI Moorland is a category C training and resettlement prison. Practice Plus Group runs healthcare services at the prison, including primary care, mental health and substance misuse services. Healthcare services are provided between the hours of 7.30am and 7.30pm Monday to Friday.

HM Inspectorate of Prisons

24. The most recent inspection of HMP/YOI Moorland was in March 2023. Inspectors reported that health care services were well led, and leaders provided clear leadership to staff. Inspectors observed a hard-working, diligent staff group delivering care with kindness and respect.

25. The substance misuse team made valuable contributions to the prison drug strategy group and worked collaboratively with mental health professionals to deliver integrated and effective care. There was good clinical support for prisoners who were receiving opiate substitution treatment. Treatment was patient centred, evidence-based and flexible, with patients clearly involved in all decisions affecting their care. Reviews took place appropriately, supported by case workers.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2023 the IMB reported that the substance misuse service continued to access those presenting as being under the influence of illicit substances within 24 hours to see if they were willing to engage with the service or needed support. An array of clinical treatments was provided for service users who had both drug and alcohol issues.

Previous deaths at HMP/YOI Moorland

27. Mr Littlewood was the fifteenth prisoner to die at Moorland since August 2020. Of the previous deaths,13 were from natural causes and one was drug related. There had been another two natural causes deaths by the end of May 2024.

Key Events

28. On 13 December 2021, Mr Richard Littlewood was remanded to HMP Doncaster. On 8 June 2022, he was sentenced to three years in prison for theft, using threatening words or behaviour and causing damage to property. This was Mr Littlewood's first time in prison. On 26 October, he was released from prison on licence. Mr Littlewood was recalled to prison on 6 January 2023 after he breached the conditions of his licence. On 27 February, he was sentenced to one year and four months in prison for breach of a restraining order. Mr Littlewood transferred to HMP/YOI Moorland on 9 March 2023.

29. Mr Littlewood had a history of substance (crack cocaine, cocaine and heroin) and alcohol misuse.

30. Mr Littlewood did not receive any visitors or make any telephone calls at Moorland.

31. When Mr Littlewood arrived at Moorland on 9 March, he went to the segregation unit after the X-ray body scanner indicated he may have concealed an illicit item. Mr Littlewood was allocated a secreted items cell (which allows staff to monitor a prisoner and includes traps in the toilet so staff can inspect and identify any items passed by the body). Healthcare staff assessed Mr Littlewood and referred him to the substance misuse service (SMS) and the mental health team.

32. A prison officer completed Mr Littlewood's first night induction interview in the segregation unit and noted that he was monitored once an hour. Mr Littlewood engaged well and was aware of the support available to him. He did not express any thoughts of suicide or self-harm.

33. Healthcare staff did not complete an initial health screen as they should have done.

34. An SMS nurse noted that Mr Littlewood was prescribed 50mls of methadone in the community. In accordance with the prison's secreted items policy, Mr Littlewood did not receive his prescribed daily dose of methadone while he was in the secreted items cell (in case of accidental overdose in combination with any illicit drugs secreted in the body). A mental health nurse saw Mr Littlewood every day and did not record any concerns. There was no evidence that the SMS team saw Mr Littlewood while he was in the segregation unit or that he was monitored for withdrawal symptoms.

35. On 10 March, a pharmacy technician reviewed Mr Littlewood's prescribed medication for gout (swelling and pain in the joints) and excess stomach acid and decided that he could not keep his medication in his cell.

36. On 11 March, a body scan did not detect any concealed items and Mr Littlewood was allocated a single cell on houseblock 1. He was allocated a keyworker who completed regular welfare checks.

37. Mr Littlewood received an initial dose of 50mls of methadone every day. This is dispensed in a clear cup and prisoners are required to drink 200mls of water (also from a clear cup) after. A prison officer is always in attendance at the medication hatch to ensure no medication is passed to other prisoners.

38. On 14 March, a mental health nurse, Mr Littlewood's SMS support worker, completed an SMS assessment. Mr Littlewood said that he had used crack cocaine and heroin and drank alcohol daily in the community. He said he had never injected drugs or overdosed. He suffered from anxiety and depression and was previously prescribed antidepressant medication. He asked to be referred to a GP for a further prescription of antidepressants but did not want to see the mental health team. Mr Littlewood's Clinical Opiate Withdrawal Scale (COWS – to assess the severity of opiate withdrawal) score was zero which indicated he was not experiencing any symptoms of drug withdrawal. Mr Littlewood's SMS support worker saw Mr Littlewood regularly over the next few weeks and did not note any concerns.

39. On 15 March, a substance misuse specialist GP at the prison saw Mr Littlewood. He confirmed Mr Littlewood's prescription of 50mls of methadone. The GP did not note any discussion about Mr Littlewood's request for antidepressant medication or his mental health. That day, a substance misuse clinical lead created a methadone maintenance care plan. She saw Mr Littlewood on 17 March and gave him lifestyle and harm reduction advice which included advice about the risk of an overdose.

40. On 21 March, the substance misuse clinical lead saw Mr Littlewood for an SMS assessment. Mr Littlewood said he wanted to remain on 50mls of methadone a day and did not have any concerns. Mr Littlewood denied using illicit substances in prison.

41. On 23 March, a healthcare assistant completed Mr Littlewood's second health screen. This was despite Mr Littlewood not receiving an initial health screen. She did not record any concerns.

42. The substance misuse specialist GP reviewed the methadone care plan on 14 April. Mr Littlewood said he felt 'rough' at night and was unable to sleep. He was sneezing, his eyes were watering and he had abdominal cramps. The GP increased Mr Littlewood's methadone dose to 60mls daily. He did not record Mr Littlewood's COWS score.

43. On 16 April, Mr Littlewood told prison staff he had suffered a seizure. A nurse noted in Mr Littlewood's medical record that he did not have a history of epilepsy and he had collected his evening meal as usual. She arranged a review for 17 April. There is no evidence that this took place.

44. On 26 April, an SMS psychosocial practitioner recorded in Mr Littlewood's medical record that he wanted to increase his methadone to 75mls because he was 'craving, thinking and dreaming about drugs'. Mr Littlewood said he wanted to remain drug free in the community and agreed to work with her on relapse prevention strategies. She sent a task to the SMS prescriber on 2 May. She did not record his COWS score. There is no evidence that the SMS prescriber considered Mr Littlewood's request and his methadone dose remained at 60mls.

45. On 16 May, Mr Littlewood approached an SMS recovery worker on the houseblock and said that he was experiencing stomach cramps, sneezing and a runny nose. Mr Littlewood asked for an increase in his methadone dose. She noted that as Mr Littlewood's SMS support worker was currently off work, his case was reallocated to the SMS psychosocial practitioner who was already aware of his request. The SMS

recovery worker did not record Mr Littlewood's COWS score. His daily methadone dose remained at 60mls.

46. On 1 June, Mr Littlewood's SMS support worker saw Mr Littlewood. His COWS score was seven which indicated moderate symptoms of opiate withdrawal. Mr Littlewood said he was not using illicit substances but experienced withdrawal symptoms in the early hours of the morning. The results of a urine test did not detect any illicit substances. The support worker told Mr Littlewood that the SMS clinic would review his methadone dose and arrange for him to be referred for an electrocardiogram (ECG- to check the heart's rhythm). Mr Littlewood did not have an ECG before he died.

47. On 9 June, a non-medical prescriber saw Mr Littlewood in the SMS clinic. Mr Littlewood said he had a runny nose, insomnia, aches and pains and sweats. She recorded his COWS score as four (mild symptoms of opiate withdrawal). Mr Littlewood asked for an increase in his methadone dose to 75mls. She agreed to increase his daily dose to 70mls with a review in four weeks. There is no evidence that healthcare staff monitored Mr Littlewood for symptoms of over-sedation or intoxication during this period.

48. On 27 June, Mr Littlewood saw the SMS psychosocial practitioner at the medication hatch and requested another increase to his methadone dose because he was in pain. She recorded in Mr Littlewood's medical record that she had sent a task to Mr Littlewood's SMS support worker to make her aware.

49. On 3 July, the non-medical prescriber held a review with Mr Littlewood. Mr Littlewood denied using illicit substances but said he was experiencing some withdrawal symptoms and wanted an increase to the methadone dose. She noted that there was no current evidence of withdrawal and Mr Littlewood was very argumentative and adamant about increasing his methadone dose. He also complained of back pain. She increased his daily methadone dose to 75mls. She did not record his COWS score.

50. That day, a nurse completed Mr Littlewood's reception health screen and did not record any concerns. Mr Littlewood's alcohol audit screen score was zero (no active alcohol use disorders). (The Head of Healthcare told the investigator that Mr Littlewood did not attend healthcare for an initial health screen on 28 March and 4 May.)

51. On 5 July, a mental health nurse held a mental health review. Mr Littlewood said one of his most significant issues was pain in his back and leg. The nurse recorded in Mr Littlewood's medical record that he did not need antidepressant medication and he did not have any current mental health needs. Mr Littlewood understood how to access mental health support.

52. On 12 July, the substance misuse specialist GP saw Mr Littlewood to review his back and leg pain. Mr Littlewood complained of severe pain and opiate withdrawal symptoms. The GP increased his daily methadone dose to 80mls.That day, Mr Littlewood's SMS support worker reviewed Mr Littlewood in the SMS clinic. Mr Littlewood said he was due for release in September and wanted to ensure that he was on a stable dose of methadone before this. He realised that poor pain management had caused him to use illicit substances in the past. Mr Littlewood

said he was tempted to use illicit substances in prison when he experienced withdrawal symptoms. The results of a urine test were negative and his COWS score was seven.

53. During a further review with the substance misuse specialist GP on 9 August, Mr Littlewood said he was still experiencing withdrawal symptoms. The GP increased his daily methadone dose to 90mls. The GP did not record a COWS score.

54. On 10 August, Mr Littlewood's SMS support worker recorded Mr Littlewood's COWs score as five (mild withdrawal symptoms) and the results of a urine test were negative. There was no evidence of methadone toxicity or over-sedation. She noted that Mr Littlewood said he was becoming increasingly irritable and anxious. Mr Littlewood received his methadone dose daily as prescribed.

Events of 24 and 25 August

55. At approximately 8.10pm on 24 August, an OSG completed the evening routine count. In a written statement, she said that Mr Littlewood was in his cell watching television and did not have any concerns. Mr Littlewood did not use his cell bell during the night.

56. At 5.25am on 25 August, the OSG went to Mr Littlewood's cell to complete the morning routine check. She looked through the observation panel and saw Mr Littlewood lying on the floor with his head between the legs of a chair. The OSG kicked the cell door, but Mr Littlewood did not respond. She radioed an emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room recorded that this occurred at 5.27am, and they called an ambulance.

57. A custodial manager and an officer arrived and entered Mr Littlewood's cell. They started CPR and attached a defibrillator which did not detect a shockable rhythm. Paramedics arrived at 5.40am and at 5.55am, confirmed that Mr Littlewood had died.

Contact with Mr Littlewood's family

58. After Mr Littlewood's death, the prison appointed a family liaison officer. The officer visited Mr Littlewood's family on 25 August and broke the news of his death.

59. The prison contributed towards the cost of Mr Littlewood's funeral in line with national policy.

Support for prisoners and staff

60. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans

to provide confidential peer-support) to identify prisoners most affected by the death.

61. After Mr Littlewood's death, a prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Littlewood's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Littlewood's death.

63. Safer custody spoke to the Samaritans and gave prison listeners and the wing manager postvention leaflets to share with prisoners and staff.

Post-mortem report

64. The post-mortem report concluded that Mr Littlewood died from methadone toxicity.

65. The pathologist commented that toxicological analysis revealed an elevated concentration in Mr Littlewood's blood sufficient to result in death in isolation. Full interpretation should take into account Mr Littlewood's history of drug use and degree of tolerance acquired.

Findings

Clinical and substance misuse care

66. The clinical reviewer concluded that while some aspects of Mr Littlewood's clinical care were equivalent to what he could have expected to receive in the community, there were some omissions in his care and she made recommendations not related to his death that the Head of Healthcare will want to address.

67. The clinical reviewer noted that Mr Littlewood received appropriate support from his SMS support worker and there was evidence of thorough assessments, care plans and follow-up support. Mr Littlewood engaged well with his SMS support worker, however, her workload pressures meant she was often unable to attend his appointments with the SMS prescribers and Mr Littlewood was seen in the SMS clinic without a planned appointment.

68. The SMS prescriber increased Mr Littlewood's dose several times without consulting his SMS case manager or support worker and they were not appropriately involved in the prescribing decisions. Healthcare staff did not always record Mr Littlewood's COWS score or consistently observe him for signs of over-sedation or toxicity. However, they did undertake frequent urine drug tests which were negative and indicated Mr Littlewood was not using illicit substances in prison.

69. Mr Littlewood's SMS support worker told the investigator that there were occasions when she would not have recommended an increase in Mr Littlewood's methadone dose based on his presentation during SMS reviews. The clinical reviewer was unable to say if Mr Littlewood's methadone dose was appropriate. We recommend:

    The Head of Healthcare at HMP/YOI Moorland should ensure that following an increase in a patient's methadone dose, healthcare staff follow the Department of Health's guidance on the clinical management of drug misuse and dependence.

70. Neither prison nor healthcare records made after Mr Littlewood's death documented whether methadone or any other illicit substance was found in Mr Littlewood's cell. We found no evidence that Mr Littlewood deliberately took more methadone than was prescribed to him.

Inquest

71. At the inquest, which took place on 19 February 2025, the Coroner concluded that Mr Littlewood's death was drug related.

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