Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Littler a prisoner at HMP & YOI Hindley on 28 August 2017

A report by the Prisons and Probation Ombudsman

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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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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Douglas Littler died in hospital on 28 August 2017 of lung cancer while a prisoner at HMP & YOI Hindley. He was 55 years old. We offer our condolences to Mr Littler's family and friends.

We are satisfied that healthcare staff referred Mr Littler to hospital at the appropriate time and that there was no delay in his cancer diagnosis. We consider that the clinical care Mr Littler received at Hindley was at least equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. Mr Douglas Littler was serving a sentence of two years and eight months for drugs offences. He was moved to HMP Hindley on 18 April 2017.

2. Mr Littler suffered from chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema), for which he was prescribed appropriate medication. He smoked cigarettes and declined help to stop.

3. On 20 June, a prison GP noted that Mr Littler had low levels of sodium in his blood and requested a repeat blood test. His sodium level remained low and on 29 June, the GP referred him to a hospital consultant.

4. Mr Littler saw a consultant physician at a hospital on the 20 July, and reported concern about needing to drink a lot of fluid and weight loss. The consultant ordered a series of tests. However, Mr Littler's health deteriorated before these could be arranged.

5. On 7 August, a prison GP examined Mr Littler and noted that he presented as confused and was breathless on minimal walking. He sent Mr Littler to hospital by emergency ambulance. On 23 August, Mr Littler was diagnosed with terminal lung cancer. He remained in hospital where he died on 28 August.

6. Mr Littler was restrained when he was taken to hospital and following two periods of disruptive behaviour, the escort chain used to restrain him was replaced with double handcuffs.

Findings

7. We are satisfied that prison healthcare staff responded appropriately to the symptoms Mr Littler presented and that there was no delay in his cancer diagnosis. We agree with the clinical reviewer that Mr Littler received a good standard of clinical care at Hindley, equivalent to that which he could have expected to receive in the community.

8. The investigation found that the level of restraint used when Mr Littler displayed challenging behaviour in hospital, was broadly proportionate to the level of risk he presented and, importantly, levels of restraint were promptly reviewed and varied when appropriate.

9. We make no recommendations.

The Investigation Process

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

11. He obtained copies of relevant extracts from Mr Littler's prison and medical records. He interviewed one member of staff by telephone on 3 October 2017.

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

13. We informed HM Coroner for Greater Manchester West District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Littler's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

Background Information

HM Prison & YOI Hindley

15. HMP & YOI Hindley is a medium security prison which can hold up to 664 adult males and young offenders on seven residential wings. The two populations are housed separately, although they mix during daily activities.

16. Bridgewater Community Healthcare NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundations Trust provide health services at the prison. The healthcare centre has outpatient facilities. Nursing staff are on site 24 hours a day and GPs provide daily clinics as well as weekend and out-of-hours support.

HM Inspectorate of Prisons

17. The most recent inspection of Hindley was in July 2016. Inspectors reported that health services were reasonably good, although nurse shortages affected primary care services and there were problems with administering medicines on time. Inspectors found that prisoners had a positive view of the service provided by GPs in managing lifelong conditions and medication reviews.

Independent Monitoring Board

18. 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 covering the year ending 31 December 2016, the IMB reported that the quality of healthcare continued to be high and comparable to the community. The number of GP clinics had increased and had resulted in lower waiting times.

Previous deaths at HMP Hindley

19. Mr Littler was the second prisoner to die of natural causes at Hindley since January 2016. There were no significant similarities between the circumstances of Mr Littler's death and the previous death at the prison.

Findings

The diagnosis of Mr Littler's terminal illness and informing him of his condition

20. On 14 February 2017, Mr Douglas Littler was sentenced to two years and eight months imprisonment for drugs offences and was sent to HMP Liverpool. He was moved to HMP Hindley on 18 April.

21. A nurse conducted an initial reception screen and noted that Mr Littler had a history of opioid dependence, for which he was prescribed methadone, and chronic obstructive pulmonary disease (COPD – the name for a collection of chronic lung diseases such as chronic bronchitis and emphysema). The next day, a prison GP prescribed appropriate inhalers and nebuliser liquid (a nebuliser is a small device that vaporises liquid medicine, which is inhaled into the lungs to help breathlessness.). He also prescribed amoxicillin (an antibiotic) and prednisolone (a steroid) to treat a flare-up of COPD, when required. Mr Littler smoked cigarettes and did not follow advice about giving up.

22. On 20 June, a prison GP reviewed Mr Littler's blood test results and noted that he had low levels of sodium in his blood. Repeat tests taken on 23 June identified that Mr Littler's sodium level remained low and he was offered a GP appointment. On 29 June, a prison GP examined Mr Littler and queried whether he had syndrome of inappropriate antidiuretic hormone secretion (SIADH - a condition that involves excessive secretion of antidiuretic hormone, causing water retention that dilutes the blood and decreases the concentration of solutes such as sodium). He noted that Mr Littler did not report any symptoms and made a hospital referral. In the meantime, prison healthcare staff conducted further investigations, including a stool sample, but did not detect anything abnormal.

23. A consultant physician reviewed Mr Littler at a hospital on 20 July. Mr Littler reported concerns about needing to drink a lot of fluid and weight loss. The consultant suspected Mr Littler was suffering from SIADH or polydipsia (excessive thirst) and suggested a series of tests, including a computerised tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body) of his chest, abdomen and pelvis. However, Mr Littler's health deteriorated before these could be arranged.

24. On 1 August, a prison GP saw Mr Littler for an emergency appointment and he reported having difficulty sleeping due to shortness of breath. He recorded that that Mr Littler had no breathing problems and prescribed him zopiclone (sleeping tablets).

25. On 7 August, a prison GP saw Mr Littler for a review and noted that he presented as confused and was breathless after minimal walking. He sent Mr Littler by emergency ambulance to the hospital where he was admitted for further investigations. Healthcare staff kept in frequent contact with the hospital for updates on his condition. On 23 August, a nurse attended a hospital multidisciplinary meeting and recorded that Mr Littler had been diagnosed with terminal lung cancer. Mr Littler's daughter and son-in-law were also present.

26. The clinical reviewer considered that the prison GP appropriately referred Mr Littler to hospital for further investigations into suspected SIADH, in line with

National Institute of Care Excellence (NICE) guidelines. Although SIADH can be linked to lung cancer in some circumstances, she considered that Mr Littler did not report any symptoms suggestive of lung cancer and that no underlying disease was suspected. The delay arranging for follow-up tests was out of the prison's control and staff appropriately arranged for Mr Littler's emergency transfer to hospital when his health deteriorated. We are satisfied that the standard of care Mr Litter received at HMP Hindley was equivalent to that which he could have expected in the community.

Mr Littler's care

27. At the multidisciplinary meeting on 23 August, hospital specialists advised Mr Littler that treatment such as chemotherapy was not an option and started an end of life care plan. Mr Littler did not return to prison and died in hospital on 28 August.

Mr Littler's location

28. We are satisfied that the prison appropriately arranged for Mr Littler's transfer to hospital on 7 August.

29. On 23 August, Mr Littler's family informed prison and hospital staff that they would like Mr Littler moved to a hospice near to where they live. The hospital palliative care team started to look for a hospice but Mr Littler died before they could find somewhere suitable.

Restraints, security and escorts

30. 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. The judgment indicated 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.

31. When Mr Littler went to hospital on 7 August, a prison manager decided that two officers should escort him using a single handcuff. Mr Littler's risk assessment indicated that he presented a low risk of escape and a medium risk to others. There was no medical input into the use of restraints. Around five hours after Mr Littler arrived at hospital, a prison manager reviewed his risk assessment and authorised staff to reduce the level of restraint to 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.) Prison staff kept Mr Littler's level of risk under review and records show that he often displayed erratic and challenging behaviour, which hospital staff attributed to his underlying medical condition.

32. On 15 August, escort officers obtained permission to remove Mr Littler's escort chain so that he could have a shower. After Mr Littler had finished showering, he

prevented staff from entering the room by using a wheelchair to block the door and was heard speaking incoherently. On 16 August, Mr Littler continued to present as agitated and confused and a prison manager authorised a three officer escort, with the option to use double handcuffs, if required. ("Double cuffing", is when the prisoner has his hands handcuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health.) At 10.40pm, escort officers noted that Mr Littler was very agitated and applied double handcuffs.

33. The next morning, a prison manager saw Mr Littler in hospital and reduced the level of restraint to an escort chain as his behaviour had improved. A risk assessment signed by a prison manager that day, indicates that Mr Littler was assessed as a high risk of escape and a high risk to the public. Records show that officers reapplied double handcuffs three days later, for around 12 hours, after Mr Littler started to pull on the escort chain and swing his arms in a threatening manner. On 25 August, Mr Littler's son-in-law asked a prison family liaison officer if staff could review his restraint and staffing level as his behaviour had improved. Later the same day, a prison manager reviewed Mr Littler's risk assessment and authorised a two officer escort with no restraints. They were not used again. We consider that cuffing arrangements were appropriately kept under review and decisions were proportionate to the assessed risk.

Liaison with Mr Littler's family

34. On 23 August, the prison appointed a prison manager as family liaison officer (FLO). The FLO attended a hospital multidisciplinary meeting and introduced himself to Mr Littler's daughter, his nominated next of kin, and son-in-law. He remained in frequent contact with Mr Littler's son-in-law, who was present at the hospital when Mr Littler died.

35. On 29 August, the FLO contacted Mr Littler's daughter by telephone to offer his condolences and support. He provided ongoing support to Mr Littler's family and attended his funeral, which took place on 14 September. The prison contributed towards the cost, in line with national policy.

Compassionate release

36. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

37. The prison started the compassionate release process on 23 August. Staff liaised with hospital doctors about a prognosis, but Mr Littler died before they could complete the application. We are satisfied that the prison appropriately considered compassionate release.

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