Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Mal Hewitt a prisoner at HMP Littlehey on 3 March 2017

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

Ms Hewitt died on 3 March 2017 of lung cancer while a prisoner at HMP Littlehey. She was 63 years old. I offer my condolences to Ms Hewitt's family and friends.

I am satisfied that the care Ms Hewitt received was equivalent to that which she 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. On 11 September 2007, Ms Mal Hewitt received an indeterminate sentence for public protection for sexual offences with a minimum term of 3 years (less 137 days spent on remand). The minimum term is the minimum time a prisoner must serve before being considered for release by the Parole Board. She initially went to HMP Parc and was transferred to HMP Littlehey on 11 July 2014. Ms Hewitt was born a male but from 2016 she identified as female (which is how she is referred to throughout this report). Ms Hewitt had a history of asthma and varicose veins.

2. On arrival at Littlehey, a nurse assessed Ms Hewitt and noted that there were no serious health concerns. In December 2014, a doctor diagnosed her with chronic obstructive pulmonary disorder (COPD).

3. Ms Hewitt was a smoker and expressed an interest in the smoking cessation services. She was not formally added to the smoking cessation services list until February 2015 and was not seen by the clinic until May 2015. Ms Hewitt had an allergy to nicotine patches, so she was given a nicorette inhaler in August 2015.

4. In May 2016, Ms Hewitt told a doctor she wanted to be referred to a lesbian, gay and transgender service in Nottingham. The doctor sent a letter to the clinic the following month, but the clinic had a waiting list of two years. Ms Hewitt did not receive an appointment prior to her death.

5. In September 2016, Ms Hewitt reported that she had a persistent sore throat and other symptoms including swollen lymph glands and a heavy feeling in her chest. Staff monitored her and when antibiotics did not improve her symptoms, they referred her to a hospital specialist who, in October 2016, diagnosed her with lung cancer.

6. There was some confusion between the family liaison officer and healthcare staff about contacting Ms Hewitt's family. Despite this, Ms Hewitt's family were kept informed of developments regarding her condition.

7. Following Ms Hewitt's diagnosis, she returned to Littlehey and was happy to stay on the wing. She was cared for appropriately and eventually moved to a suite furnished to cater for her needs. On 22 February, after a significant deterioration in her condition she was moved to a hospice. Ms Hewitt died on 3 March with her family by her side.

Findings

8. The clinical reviewer found that the care Ms Hewitt received was equivalent to that which she could have expected to receive in the community. Staff investigated her symptoms swiftly, and promptly referred her for specialist help when her symptoms did not improve. The care Ms Hewitt received from the prison following her diagnosis was good and her needs as a transgender prisoner were appropriately managed.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Ms Hewitt's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Ms Hewitt's clinical care at the prison.

12. We informed HM Coroner for Bedfordshire District of the investigation who gave us the accepted cause of death in the absence of a post mortem. We have sent the coroner a copy of this report.

13. The investigator wrote to Ms Hewitt's sister 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.

14. The investigation has assessed the main issues involved in Ms Hewitt's care, including her diagnosis and treatment, whether appropriate palliative care was provided, her location, security arrangements for hospital escorts, liaison with her family, and whether compassionate release was considered.

15. The report refers to Ms Hewitt as 'she' throughout on account of the evidence that it was her preference to identify as female. This preference was largely acceded to by the prison.

16. 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.

Background Information

HM Prison Littlehey

17. HMP Littlehey, Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the prison population are convicted of sexual offences.

18. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care. Prisoners with life long conditions were identified effectively and nurses with additional specialist training provided relevant clinics. There was excellent and compassionate joint working between the healthcare provider, prison and community services for prisoners with palliative care and end-of-life needs.

Independent Monitoring Board

20. 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 January 2016, the IMB reported that the transfer to a new healthcare provider in April 2015 went smoothly with no adverse impact on service delivery.

21. The Board recognised the significant demands the elderly prison population made upon healthcare services, in particular the increasing number of hospital escorts, subsequent stays and the resulting risks associated with the redeployment of staff. They also expressed concern about future funding.

Previous deaths at HMP Littlehey

22. Ms Hewitt's is the eleventh death from natural causes at Littlehey since the beginning of 2016. There are no similarities to any of the previous deaths at Littlehey.

Transgender prisoners

23. Prison Service Instruction (PSI) 07/2011 on the care and management of transgender prisoners, covers medical treatment, living in an acquired gender role and the legal position for doing so. Gender reassignment is a protected

characteristic under the Equality Act 2010, and prisoners must not be discriminated against or harassed because of it.

24. The national instruction says that governors must allow prisoners who consider themselves transgender and who wish to begin gender reassignment to live permanently in their acquired gender. This includes allowing them to dress in clothes appropriate to their acquired gender, use gender appropriate names and access the items they use to maintain their gender appearance at all times.

25. PSI 17/2016 on the care and management of transgender offenders was released in November 2016. The policy focuses on transgender prisoners who have expressed a consistent desire to live permanently in their acquired gender but also includes intersex, non-binary and gender fluid prisoners.

26. The national instruction says that all transgender prisoners must be allowed to express their gender identity, including dressing in clothes suited to their acquired gender. Transgender prisoners must be allowed to adopt a gender-appropriate or gender-neutral name and others must consistently address them using their preferred name.

27. In January 2017, we published a Learning Lessons Bulletin on transgender prisoners, which summarised the lessons that need to be learned from our investigations into the deaths of and complaints from transgender prisoners. These lessons include the need for meaningful contact between personal officers and transgender prisoners, for proactive evaluation of the location for a transgender prisoner and for reasonable adjustments that do not compromise security to help transgender prisoners to live in their gender.

Findings

The diagnosis of Ms Hewitt's terminal illness and informing her of her condition

28. On 11 September 2007, Ms Mal Hewitt received an indeterminate sentence for public protection for sexual offences with a minimum term of 3 years (less 137 days spent on remand). The minimum term is the minimum time a prisoner must serve before being considered for release by the Parole Board. She initially went to HMP Parc and was transferred to HMP Littlehey on 11 July 2014. Ms Hewitt was born a male but from 2016 she identified as female (which is how she is referred to throughout this report). Ms Hewitt had a history of asthma and varicose veins.

29. On arrival at Littlehey, a nurse saw Ms Hewitt for her first night screen and did not note any significant health concerns. The nurse described her as 'fit and well' and a smoker who used up to one ounce of tobacco a week.

30. On 3 December, Ms Hewitt had an annual asthma review with a nurse. Ms Hewitt said that she didn't actually have asthma, only asthma symptoms and had smoked in the past. She said she was not on any current medication but had blocked sinus symptoms morning and night, with no breathlessness at night. The nurse suspected that Ms Hewitt had chronic obstructive pulmonary disease and booked her an appointment to see a prison GP.

31. A prison GP saw Ms Hewitt on 8 December and diagnosed COPD. He prescribed an inhaler, advised Ms Hewitt to stop smoking and noted that he had 'gathered' that she was on the smoking cessation service list. However, on 17 February 2015, a dentist noted that he put Ms Hewitt on the smoking cessation list. This was the first time Ms Hewitt was added to the list at Littlehey.

32. On 7 May 2015, Ms Hewitt attended the smoking cessation advice clinic but declined the course of treatment because she said she was allergic to niquitin patches and would return to the clinic when alternative treatment was available. A nurse reviewed Ms Hewitt's case on 20 May and established that the patches gave her a rash. Champix (a tablet to aid smoking cessation) was not available at Littlehey and the pharmacy was out of stock of the lozenges which also aided smoking cessation. She considered giving Ms Hewitt a nicorette inhaler but told her to try the patches once more and if she had an allergic reaction, they would prescribe a nicorette inhaler.

33. On 15 June, a nurse noted Ms Hewitt had not been to the pharmacy to collect her patches. A healthcare assistant saw Ms Hewitt on 18 June and advised her that the composition of patches had changed since she had last tried them and they were only asking her to try them for 24 hours to gauge how she reacted. She asked her to come back the following day to get a patch, but Ms Hewitt did not go back. On 14 July, Ms Hewitt asked the healthcare assistant for a patch and nicorette inhaler. She told her to try the patch first.

34. On 16 July 2015, the healthcare assistant saw Ms Hewitt and noted that she had had an adverse reaction to the patches. She agreed Ms Hewitt should be prescribed a nicorette inhaler and an appointment would be made for two weeks time. A nurse prescribed a nicorette inhaler on 5 August. By 29 October, Ms

Hewitt successfully stopped smoking and no further nicorette inhalers were prescribed.

35. In December 2015, Ms Hewitt was treated at hospital for inflamed varicose veins. The hospital prescribed anticoagulants and compression stockings. The clinical reviewer noted that inflamed varicose veins could be indicative of cancer.

36. On 25 May 2016, Ms Hewitt told a prison GP she wished to be referred to the Lesbian, Gay, Bisexual and Transgender service and the GP sent the referral letter the following month. However, the clinic had a 2 year waiting list for appointments.

37. On 21 September, a nurse saw Ms Hewitt who complained of a sore throat. The nurse noted that she had slightly swollen lymph glands and probably had an upper respiratory tract infection. She gave Ms Hewitt a COPD rescue pack and a new inhaler for her asthma. Ms Hewitt saw a prison GP on 29 September because she still had a sore throat and headache. The GP prescribed paracetamol and advised her to take plenty of fluids. He told Ms Hewitt to make an urgent appointment if her symptoms got worse.

38. On 4 October, a nurse saw Ms Hewitt and noted she looked unwell. Ms Hewitt described a feeling of something on her chest, through her back and on her shoulder and she was breathless. Her records indicated that she was smoking again. Ms Hewitt asked her to change her first name to 'Mal' but she noted that until it was formally changed she could not do this, but changed Ms Hewitt's title details from Mr to Ms. She also referred Ms Hewitt to a doctor for an urgent appointment.

39. A prison GP saw Ms Hewitt and examined her chest and throat and prescribed antibiotics and steroids. On 10 October, he reviewed Ms Hewitt again and noted her condition had not improved. He suspected a probable exacerbation of COPD and arranged for Ms Hewitt to be admitted to hospital.

40. Hospital staff treated Ms Hewitt for a COPD exacerbation and when she did not respond to treatment they took a CT scan (Computerised Tomography produces a detailed image of the inside of the body) on 12 October. The scan revealed a growth in Ms Hewitt's upper chest. Staff at another hospital took a biopsy on 17 October, which confirmed that Ms Hewitt had lung cancer.

41. The clinical reviewer found that healthcare staff appropriately investigated Ms Hewitt's symptoms and referred her to specialists when her symptoms worsened.

42. Although there was a delay getting Ms Hewitt on the smoking cessation list, the clinical reviewer was satisfied that Ms Hewitt's treatment in relation to smoking cessation was equivalent to that which she could have expected to receive in the community.

Ms Hewitt's clinical care

43. Ms Hewitt started chemotherapy at the hospital before returning to Littlehey on 31 October 2016. A nurse visited her in hospital on 28 October and another nurse discussed Ms Hewitt's medication and chemotherapy programme with hospital staff. A hospital doctor told the nurse that Ms Hewitt had a prognosis of

8-10 months and a Do Not Attempt Cardiopulmonary Resuscitation order was in place. (DNACPR: In the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care would continue to be provided.)

44. On her return to Littlehey, Ms Hewitt was fully independent and able to care for herself. She was on a number of medications including morphine. On 1 November, a nurse visited Ms Hewitt on the wing to discuss her diagnosis and prognosis. Ms Hewitt assured the nurse that her pain was under control and that she was happy on the wing and had everything she needed. The nurse told Ms Hewitt that she and another nurse would visit her for regular updates. A prison GP also saw her that day and discussed her medication, chemotherapy schedule and concerns about DNACPR. Ms Hewitt said she wanted to rescind the order and wanted to discuss it another time. The GP agreed to do this.

45. On 12 November, a nurse opened a number of care plans covering pain, palliative care and 'death and dying'. Ms Hewitt continued to receive palliative chemotherapy in hospital every three weeks. On 22 November, Ms Hewitt completed an Advanced Care Directive and clarified that her preferred place to die was a hospice. She began to deteriorate and in December the nurse increased her pain management medication after a discussion with a prison GP.

46. By January 2017, Ms Hewitt had developed pressure sores. A nurse ordered a special mattress for her and later asked for a grab rail to be put in Ms Hewitt's bathroom.

47. In February, Ms Hewitt deteriorated further and on 8 February, a nurse discussed DNACPR with Ms Hewitt again. She agreed that an order should be in place and the nurse made the arrangements. Ms Hewitt was using a wheelchair and was weak.

48. On 22 February, a hospital doctor contacted a prison GP with the news that Ms Hewitt's CT scan showed the disease had progressed to the extent that hospice care was now appropriate. Ms Hewitt was admitted to a hospice the same day. Prison healthcare staff kept in touch and visited Ms Hewitt until she died on 3 March at 3.30pm.

49. The clinical reviewer found that the care Ms Hewitt received was compassionate and of a good quality and there was effective liaison between healthcare staff and the consultant in palliative care.

Ms Hewitt's location

50. Following her diagnosis, Ms Hewitt made it clear that she wished to stay on the wing surrounded by her friends. Healthcare staff visited her regularly and made modifications to her living arrangements, including a special mattress and a hand rail. On 14 February she was moved to a cell with a 'dignity suite' on A wing (next to healthcare), which included a hospital bed, raised toilet seat and an armchair. We are content that Ms Hewitt's needs were met in line with her wishes.

Restraints, security and escorts

51. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

52. Ms Hewitt was accompanied by two officers when she was moved to the hospice on 22 February 2017. Appropriately, no restraints were applied.

Liaison with Ms Hewitt's family

53. Following Ms Hewitt's diagnosis on 17 October 2016, a prison manager was appointed as a family liaison officer. She visited Ms Hewitt in hospital on 18 October and talked to her about contacting her sister, but Ms Hewitt did not want any family contact. She visited her again at Littlehey on 4 November but Ms Hewitt was clear that she did not want her to contact her sister. The manager said that she would see her every few weeks and asked Ms Hewitt to alert the wing staff if she changed her mind or wanted to speak to her in the meantime. There is nothing documented in the FLO log to indicate that the manager made additional visits to see Ms Hewitt about family contact.

54. On 9 January, Ms Hewitt asked a nurse to ring her sister and give her the full details about her illness. The nurse tried to make contact with Ms Hewitt's sister, but was unsuccessful. On 20 January, a prison GP telephoned Ms Hewitt's sister and gave her information about Ms Hewitt's illness, what to expect if she visited and that Ms Hewitt now dressed in women's clothing. The GP kept in touch with her about Ms Hewitt's illness and on 21 February spoke to her about Ms Hewitt's imminent move to a hospice.

55. On 21 February, the prison manager went to speak to Ms Hewitt before she was transferred to the hospice. The manager saw a prison GP, who told her that she was going to ring Ms Hewitt's sister to tell her of the move as they had already been in touch. She was unaware that the GP was in contact with Ms Hewitt's family or that Ms Hewitt had agreed for her family to be contacted.

56. The prison manager called Ms Hewitt's sister on 21 February and introduced herself. She met her at the hospice the following day and gave more detail about her role. She stayed in touch with Ms Hewitt's family, offering support and advice. Ms Hewitt's family were with Ms Hewitt when she died.

57. Ms Hewitt's funeral was held on 27 March. The prison manager and her deputy from the prison attended. The prison contributed to the costs of the funeral in line with national policy.

58. The prison manager was not aware that healthcare staff were in contact with Ms Hewitt's family. Although she had said she would make occasional visits to Ms Hewitt to gauge how she felt about family contact there is no evidence to indicate that this happened. However, she gave Ms Hewitt the option to alert officers if

she changed her mind and offered to speak to her again about family contact or any other issues but Ms Hewitt did not make contact with her. While communication between healthcare staff and the manager could have been better the family were kept up to date about Ms Hewitt's condition and her family did not raise any concerns. We therefore make no recommendation.

Compassionate release

59. 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.

60. On 1 November, a nurse visited Ms Hewitt on the wing and discussed her wishes for compassionate release. Ms Hewitt confirmed that she wished to be considered for it. However, because she initially responded well to chemotherapy and the tumour shrank, it was difficult for specialists to give a prognosis. The prison submitted a compassionate release application on 24 February 2017 but the application was rejected by the Safer Custody and Public Protection Group (SCPPG) because the Governor did not support Ms Hewitt's early release on account of her being in denial of her offences and the application itself was incomplete.

61. On 27 February, a specialist confirmed that Ms Hewitt had less than three months to live. The information was forwarded to SCPPG on 28 February but SCPPG officials wanted clarification whether the Governor supported the application in light of the prognosis and whether the application would now be fully completed. Ms Hewitt died before the application was fully completed.

62. We are content that the prison started early conversations about compassionate release and that the difficulty in securing a prognosis made it difficult to progress the compassionate release application further.

Transgender prisoners

63. Prison Service Instruction (PSI) 7/2011 'The Care and Management of Transsexual Prisoners', which was in force when Ms Hewitt was at Littlehey, contains a mandatory instruction that "permitting prisoners to live permanently in their acquired gender will include allowing prisoners to dress in clothes appropriate to their acquired gender and adopting gender-appropriate names and modes of address".

64. We are content that the prison facilitated Ms Hewitt's wish to identify as female and that when she vocalised this desire in May 2016, a prison GP appropriately referred her to a specialist clinic.

65. PSI 17/2016 'The Care and Management of Transgender Offenders' replaced PSI 7/2011 and it contains a mandatory instruction that "transgender prisoners must be allowed to adopt a gender-appropriate or gender-neutral name and be addressed by others consistent with the gender (or neutral gender) they identify with".

66. Although generally the records reflected Ms Hewitt’s preferred identity as female, this was not always the case within the prison records and we would like the Governor to remind staff of the importance of this.

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