Action Plan in response to the PPO Report into the death of

Mr David James Suttie on 03.02.2021 at HMP Littlehey

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare and the Governor should: ensure that Littlehey has a Transition of Care policy setting out formal, mandatory procedures for both healthcare and prison staff when a prisoner returns from hospital or a hospice, including: • the responsibilities of healthcare and prison staff; • notification processes; • reassessment of the prisoner's needs, including all risk assessments; • frequency of required	Accepted	Guidance document (Transition of care guidance from Hospital to HMP Littlehey) has been completed and signed by Healthcare, HMPPS and Social Care in August 2021. This document sets out respective responsibilities, notification processes, all risk re/assessments, monitoring requirements, key safety and an escalation process.	Healthcare HMPPS Social Care	Complete

	checks/observations; • the use/reconnection of key safety equipment (such as a falls monitor); and • escalation procedures; and ii. consider appointing a member of healthcare staff as a shift co-ordinator to lead on this to provide adequate oversight and discharge of these duties.				
2	The Head of Healthcare should share this report with HCA A and discuss the Ombudsman's findings with her.	Accepted	This report has been shared with HCA A and discussed in her supervision on 19 October 2021.	Head of Healthcare	Complete
3	The Head of Healthcare should review the local Falls Risk Assessment policy to ensure that referral processes and assessments are completed and updated. This should be done in conjunction with the creation of the Transition of Care policy.	Accepted	The falls risk assessment is now embedded in the secondary reception screening template. However for those already residing within HMP Littlehey who meets the criteria have been added to a risk of falls waiting list. These will then be picked up by the nursing staff and clinics booked to complete these accordingly. On completion of the risk assessment a falls leaflet is given and if required a SCARF is completed for a social care assessment. All staff have attended the Fall prevention training. However in line with training anyone under the age of 65 who has no history of falls will not be risk	Head of Healthcare	Complete

			assessed. Falls risk assessments are being completed for all residents over the age of 65 or have a history of falls and where appropriate a SCARF form is being completed for Social care support. We feedback those who are at risk of falls in the Prison SIM meeting and the prison (Safer Custody) is then responsible to disseminate this information to the wing staff.		
4	The Governor and the Head of Healthcare and should consider how best to share important information about a prisoner's care (such as prisoners identified as a falls risk and/or with active DNACPR forms) so that it is easily and readily accessible to prison staff and healthcare staff.	Accepted	Residents are encouraged to wear DNACPR wrist bands and a copy of the form displayed in their cell but it is a personal choice (set out in a Standard Operating Procedure). The prison wing office has a resident's board which highlights all prisoners on the wing with DNACPR in place. It is our intention to respect the wishes of our patients by ensuring all staff has a visible means of identifying all those who do not wish to be resuscitated. The Prison reviewed the DNACPR process and a new process to be implemented. No photocopies of DNACPR will exist and process for the paperwork to go with them to hospital has been devised and will	Head of Healthcare	Complete

			be implemented.		
5	The Governor should: • work with the Head of Healthcare as a matter of urgency to ensure that the prison has a safeguarding structure in place in line with national policy; • ensure that all staff are familiar with and understand their responsibilities under PSI 16/2015; and • engage with the local authority's Safeguarding Adults Board.	Accepted	An initial meeting was held on the 20 August 2021 with NHS England and NHS improvement; this was attended by healthcare, prison and social care lead from the local authority. A further meeting was held in November 2021 to establish a process and to set up the necessary structures. There is currently a local safeguarding policy (2019) that is being reviewed. Completion for this review is 30 November. This review is being completed in conjunction with PSI 16/2015 and will be communicated to all staff when completed. The structure of safeguarding will form part of the review and will be published along with the review and actions for staff. The Cambridgeshire and Peterborough Safeguarding Partnership Board have been contacted in order to develop partnership working.	Head of Healthcare Governor	November 2021 November 2021
6	The Governor, Head of Healthcare and NHS England should share the key findings of this report with social care colleagues in the prison and in the local authority. Focus should be given to the concerns about adequate safety equipment (e.g. falls	Accepted	The Ombudsman's report was shared with social care and health colleagues in October 2021. The identified concerns were discussed at the November 2021 Social care and safeguarding meeting.	Head of Healthcare/The Governor/Social Care	November 2021

	detectors) and the lack of local authority investigation of the safeguarding referral made by the healthcare team.				
7	The Governor and the Head of Healthcare should oversee the roll out of the integrated care model (in partnership with local authority colleagues) with clear escalation procedures if they are unable to deploy safety equipment immediately.	Accepted	This has been covered in the above mentioned response to recommendation 1, through the Transition of care guidance from Hospital to HMP Littlehey.		
8	The Governor should commission an investigation into allegations that prison bed watch staff were asleep while on duty on the night of 27/28 January 2021, with a view to considering whether disciplinary action is appropriate.	Accepted	We will commission a Management Inquiry to establish if there is evidence to support a disciplinary investigation.	Governor	November 2021