

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Suttie, a prisoner at HMP Littlehey, on 3 February 2021

A report by the Prisons and Probation Ombudsman

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.

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

Mr David Suttie died of lung cancer at HMP Littlehey on 3 February 2021. COVID-19 was a contributory cause. Mr Suttie was 71 years old. I offer my condolences to his friends.

Mr Suttie had been diagnosed with lung cancer in December 2020. The clinical reviewer concluded that the clinical care that Mr Suttie received at Littlehey for his ongoing palliative and long-term conditions was of a reasonable standard and equivalent to that which he could have received in the community.

However, I share her concern that there were significant gaps in the safe transfer of care processes when Mr Suttie was discharged from hospital and returned to Littlehey on the afternoon of his death. The failure to share information between prison and healthcare staff meant that healthcare staff did not see Mr Suttie when he returned and he was left unsafe in a bed without a guard rail, naked and without his falls alarm. He was found dead on the floor of his cell about one and a half hours later.

We raised serious concerns about safeguarding at Littlehey in a previous investigation into a death that took place in March 2020, and again following our investigation into a death in March 2021. It is therefore very worrying to see another case of this kind. I have recommended that the Governor puts a prison safeguarding structure in place, in line with national policy, as a matter of urgency.

I am also concerned that it is alleged that the prison staff, who were on bed watch with Mr Suttie at a hospice on the night of 27/28 January were asleep on duty.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2022

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	8
Findings.....	12

Summary

Events

1. On 2 December 2016, Mr David Suttie received a 13-year prison sentence for sexual offences. On 27 December 2019, Mr Suttie transferred to HMP Littlehey.
2. Mr Suttie had a number of long-term and complex health conditions including diabetes, hypertension, heart disease, liver damage and depression. He had also had a heart attack and a suspected stroke.
3. His medical conditions made him extremely clinically vulnerable if he contracted COVID-19, and from March 2020 onwards he followed a shielding regime at Littlehey.
4. From December 2020, Mr Suttie's health began to deteriorate and he fell out of bed on a number of occasions. On 23 December, he was sent to hospital after abnormal blood tests and the following day, he was diagnosed with lung cancer that had spread to other parts of his body.
5. On 8 January 2021, Mr Suttie was transferred from hospital to a hospice. On 13 January, he tested positive for COVID-19.
6. On 28 January, he returned to Littlehey at his own request as he had said he wanted to die there. He was seen by healthcare staff and prison staff put hourly welfare checks in place during the day and night.
7. Late on 2 February, he was found on the floor of his cell after falling out of bed and he was taken to hospital in the early hours of 3 February. After assessment, the hospital discharged him, and he arrived back at Littlehey at about 1.40pm that day. Ambulance staff put him to bed in his cell and prison staff reinstated the hourly welfare checks. He was not seen by healthcare staff.
8. At 3.10pm, Mr Suttie was found unresponsive on the floor of his cell during a welfare check. A medical emergency code was called and healthcare staff attended. They did not attempt to resuscitate him as he had a Do Not Attempt Resuscitation order in place.
9. A prison GP certified that Mr Suttie's death was caused by lung cancer, with COVID-19 as a contributory factor.

Findings

Clinical care

10. The clinical reviewer concluded that the clinical care Mr Suttie received in prison for his long-term conditions and palliative care needs was of a good standard and equivalent to that which he could have expected to receive in the community.

11. However, we share the clinical reviewer's concerns that there was a failure in the handover and transfer of care procedures between prison healthcare staff, prison staff and the ambulance crew when Mr Suttie returned to Littlehey from hospital on 3 February. The clinical reviewer said that Littlehey's information sharing systems and processes failed at multiple points during the hospital discharge process because there was no Transition of Care policy in place.
12. As a result, healthcare staff did not see Mr Suttie before he died, and he was left in an unsafe situation.
13. When Mr Suttie returned to the prison from the hospice on 28 January, healthcare staff did not complete a falls risk assessment, although Mr Suttie was known to be at risk of falls.
14. On the day of his death, Mr Suttie was not wearing his falls detector alarm.
15. A hospice nurse alleged that the prison officers who escorted Mr Suttie at the hospice were asleep on duty on the night of 27/28 January. This needs to be investigated.

Recommendations

- The Head of Healthcare and the Governor should:
 - i. 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 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.
- The Head of Healthcare should share this report with HCA A and discuss the Ombudsman's findings with her.
- 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.
- The Governor and the Head of Healthcare 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.

- 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.
- 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 (eg falls detectors) and the lack of local authority investigation of the safeguarding referral made by the healthcare team.
- 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.
- 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.

The Investigation Process

16. The PPO 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.
17. The PPO investigator obtained copies of relevant extracts from Mr Suttie's prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Suttie's clinical care at the prison. The investigator and the clinical reviewer interviewed five members of staff on 8 and 12 April and 7 May 2021. The investigator interviewed one staff member on 12 April 2021. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic. In addition, we received three written statements from staff.
19. We informed HM Coroner for Cambridgeshire of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.
20. Mr Suttie had no recorded next of kin.
21. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy, relating to Littlehey's safeguarding policy, and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Littlehey

22. HMP Littlehey is a medium security training prison, holding more than 1,200 adult male prisoners. Among the population nearly half are over the age of 50 and around 18% of prisoners are over 65.
23. Primary Care services are provided by Northamptonshire Healthcare NHS Foundation Trust (NHFT). Nurses are on duty between 7.30am and 7.30pm Monday to Friday, and from 8.00am to 5.30pm 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 (HMIP)

24. The most recent full inspection of HMP Littlehey was an unannounced inspection in August 2019. Inspectors reported that Littlehey was a calm and safe prison with very little record of violence. The prison was generally clean and well maintained but there were ongoing problems with overcrowding and with the heating system which caused significant issues. Healthcare was considered to be good and prisoners were positive about the quality of healthcare they received.
25. HMIP also conducted a short scrutiny visit to Littlehey in June 2020 to look at how the prison was responding to the COVID-19 pandemic. Inspectors reported that the prison had adopted clear plans to manage the pandemic at the start of the lockdown. Littlehey was an official outbreak site between March and April 2020. HMIP reported that the prison, in conjunction with Public Health England (PHE), had taken swift action to control the spread of the virus and managed to bring infection rates down to a manageable level. However, inspectors found that, although health and safety protocols were in place, social distancing was difficult to maintain in small offices and corridors despite best efforts.

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 January 2020, the IMB reported that Littlehey continued to be a safe, fair and decent prison. They reported that the opportunities and facilities for older prisoners had decreased, but that access to the healthcare unit on the first floor had been improved. They said that the provision of social care and healthcare at Littlehey was recognised as a model of good practice.

Previous deaths at HMP Littlehey

27. Mr Suttie was the 23rd prisoner to die at HMP Littlehey since February 2019. Of the previous deaths, 21 were from natural causes, and one was self-inflicted. There have been nine deaths from natural causes since Mr Suttie's death, including one COVID-19 related death.
28. We raised serious concerns about safeguarding at Littlehey in a previous investigation into the death of an elderly man in March 2020 who was left lying on

the floor of his cell for several hours overnight following a fall. We were also concerned that the prison's internal investigation into how this happened was insufficiently robust. In December 2020, the Head of Healthcare told us that all healthcare staff had been sent a copy of the adult safeguarding policy and asked to familiarise themselves with it and that the policy would be part of the mandatory annual training for healthcare staff.

29. We are also aware that an adult safeguarding referral was made in March 2021, after an elderly prisoner with COVID-19 was left sitting on his cell toilet for 14 hours overnight and was subsequently taken to hospital with hyperthermia.

COVID-19 (coronavirus)

30. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
31. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
32. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Safeguarding

33. Prison Service Instruction (PSI) 16/2015, *Adult Safeguarding*, sets out the duty of care and requirements on prisons to protect adults, particularly vulnerable adults. Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect. Prison staff have a common law duty of care to prisoners that includes taking appropriate action to protect them. Prisons should have a range of processes in place to ensure that this duty is met.
34. These processes should ensure that prisoners who are unable to protect themselves as a result of care and support needs are provided with a level of protection that is equivalent to that provided in the community. Definitions of abuse and neglect are based on those used in the Care and Support Statutory Guidance issued by the Department of Health in October 2014.

35. Responsibility for safeguarding in prisons rests with the Governor, who must appoint a prison manager to lead on safeguarding. The PSI encourages Governors to be proactive in engaging with the relevant local authority's Safeguarding Adults Board, both at a strategic level and as a source of advice and assistance in safeguarding prisoners.

Key Events

36. On 2 December 2016, Mr David Suttie received an Extended Determinate Sentence of 13 years for sexual offences and was sent to HMP High Down. On 27 December 2019, he transferred to HMP Littlehey.
37. Mr Suttie had a number of long-term and complex health conditions including diabetes, hypertension, heart disease, liver damage and depression. He had had a heart attack in 2013 and a suspected stroke in 2016. Mr Suttie was noted to have used a wheelchair prior to arriving in prison, although there did not appear to be any medical reason for him to do so. While in prison, Mr Suttie saw a physiotherapist to encourage him to move about independently and improve his confidence when walking.
38. Mr Suttie was located on J Wing, a wing for older and vulnerable prisoners with challenging health needs.
39. In March 2020, restrictions began to be imposed in response to the COVID-19 pandemic. Because of his health conditions, Mr Suttie was identified as clinically extremely vulnerable if he contracted the virus and, on 29 March, he was placed on the prison's COVID-19 shielding regime. He continued to shield throughout his time at Littlehey.
40. On 23 March 2020, following consultation with a Palliative Care Consultant, Mr Suttie signed a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form. This meant that he agreed that he did not want to be resuscitated in the event of a heart attack or if he stopped breathing.

December 2020

41. On 9 December, Cambridgeshire Adult Social Care approved a social care plan for Mr Suttie for three social care visits per week.
42. On the evening of 18 December, prison staff found Mr Suttie on the floor of his cell. Prison officers and social care staff helped him back into bed. Mr Suttie told them he was fine. On 20 December, a nurse noted that Mr Suttie had fallen from his bed again the previous night. She recorded that he had deteriorated and looked frail and was using a Zimmer frame to move about.
43. On 21 December, Mr Suttie had a series of blood tests taken by a nurse who was concerned about the deterioration in his health. She asked prison staff to get some bed rails for his bed. On the same day, social care staff requested a falls detector (a bracelet or pendant device worn by a patient that detects a fall and sends an emergency call). Social care staff also asked healthcare staff to complete a falls assessment.
44. On 22 December, a nurse referred Mr Suttie for a falls assessment, but this did not take place.
45. On 23 December, Mr Suttie suffered another fall. Prison staff decided to carry out a welfare check on Mr Suttie every two hours and asked that he should be referred for a falls detector. Social care staff increased the frequency of their visits to twice a day.

46. On the same day, Mr Suttie's blood test results came back and showed he had hypercalcaemia (high calcium levels). A prison GP spoke to staff at Hinchinbrooke Hospital who advised that Mr Suttie needed to go to A&E, and he was taken to hospital by emergency ambulance.
47. On arrival at hospital Mr Suttie had a chest X-ray and scans. On 24 December, he was diagnosed with lung cancer which had spread to his adrenal glands and liver. He was referred to St John's Hospice for assessment and pain management.
48. On 29 December, while Mr Suttie was in hospital, a Vibby falls detector arrived at the prison for him.
49. On 30 December, a nurse spoke with the hospital and noted on Mr Suttie's medical record that he had been placed on a palliative care plan (meaning that his condition was not curable and that treatment would be designed to make him as comfortable as possible). Staff at Littlehey started the paperwork for Early Release on Compassionate Grounds (ERCG).

January 2021

50. On 8 January 2021, Mr Suttie was transferred from Hinchinbrooke Hospital to St John's Hospice. He was not restrained but was escorted by two prison officers throughout his time at the hospice. On arrival he had a COVID-19 test and the result was negative. On 13 January, Mr Suttie tested positive for COVID-19 in the hospice.
51. At around 11.45pm, on 27 January, a nurse at the hospice noticed that all the lights in Mr Suttie's room were off and the room was dark. She entered his room and told the prison officers that a light needed to be on at all times to enable nursing staff to observe the patients.
52. At 3.30am on 28 January, another nurse at the hospice entered Mr Suttie's room to check on him. She called out to Mr Suttie and the escorting prison officers but got no reply. She called out twice more before one officer responded to her. She told them that they were asleep, which they were not supposed to be, and that this was a disciplinary offence. One officer denied being asleep and the other did not respond. The nurse reported the incident to the nurse in charge of the hospice.
53. That afternoon, Mr Suttie returned to Littlehey after telling staff that he would prefer to die in prison rather than the hospice. He was seen by healthcare staff on his return to the prison. There is no evidence that a falls assessment was completed. Prison staff placed him on hourly welfare checks throughout the day and night as they were concerned about his ability to call for help, particularly his ability to press his falls bell (which doubled as a personal alarm). Social care staff increased his visits to four per day.

Events of 2 and 3 February

54. At 10.55pm on 2 February, an Operational Support Grade (OSG) checked Mr Suttie as part of the hourly welfare checks. She found he had fallen from his bed and was sitting on the floor. She alerted the night orderly officer (the officer in

- charge of the prison overnight). As there were no healthcare staff on duty overnight, prison staff called an ambulance at 11.20pm and stayed with Mr Suttie until the ambulance arrived at just after midnight on 3 February. Paramedics assessed Mr Suttie and at 2.11am, he was taken to Hinchinbrooke Hospital.
55. When he arrived at Hinchinbrooke Hospital, Mr Suttie tested positive for COVID-19. However, hospital staff assessed that Mr Suttie was not infectious and that the positive test was a legacy of his positive result on 13 January. While at hospital, Mr Suttie was verbally abusive to staff. He tried to get out of his hospital bed but slipped and was put back into bed by nurses.
 56. By late morning, doctors assessed he had suffered no injuries from his fall and that he was well enough to return to the prison. The hospital rang the healthcare department in the prison and a nurse noted in Mr Suttie's clinical record that he was due to be discharged that day.
 57. At around 1.15pm, Mr Suttie left the hospital with two prison officers, in a Hinchinbrooke Hospital ambulance. He was wearing a hospital gown. The ambulance arrived at Littlehey at around 1.40pm. The officers escorted Mr Suttie and the ambulance staff onto the wing and gave wing staff a verbal handover. Prison staff on the wing were not expecting Mr Suttie back.
 58. The ambulance staff transferred Mr Suttie from the ambulance stretcher to his own bed. The cell was locked, and Mr Suttie was again verbally abusive to prison staff. Prison staff restarted the hourly welfare checks.
 59. After leaving the wing, one of the escorting officers returned the escort bag to the prison security department. He said in his written statement that he then took Mr Suttie's hospital discharge paperwork to the prison's healthcare office. Healthcare Assistant (HCA) A was working in the healthcare office that afternoon. At interview she said she did not receive any discharge paperwork before she moved from the office to the dispensary at around 3.00pm to deliver afternoon medications.
 60. At 2.10pm a wing officer checked on Mr Suttie through the observation panel in the cell door. He saw Mr Suttie was in bed, moving and conscious.
 61. At 3.10pm, the officer checked on Mr Suttie again and saw him lying on the floor of his cell. The officer immediately called a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and entered the cell. The prison control room called an emergency ambulance.
 62. At 3.15pm, healthcare staff responding to the code blue arrived at Mr Suttie's cell. A nurse and HCA A and assessed him. Mr Suttie was lying in a foetal ball on the floor, naked from the waist up, his lower half covered by a blanket. When this was removed, he was found to be completely naked. His Vibby falls detector was not on his wrist or around his neck. His bed was set to the highest setting possible and there was no bed guard up.
 63. Mr Suttie had no pulse or other signs of life. Staff knew he had a DNACPR and did not start resuscitation, although body-worn camera (BWC) footage shows that there was considerable confusion while staff searched for the DNACPR paperwork (which was still in the healthcare centre with Mr Suttie's hospital

discharge papers). The nurse and HCA A contacted a prison GP, and at 3.29pm she certified that Mr Suttie had died.

Contact with Mr Suttie's family

64. Mr Suttie had no recorded next of kin. Littlehey paid for his funeral in line with national instructions.

Support for prisoners and staff

65. After Mr Suttie's death, a manager debriefed the staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
66. The prison posted notices informing other prisoners of Mr Suttie'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 Suttie's death.

Cause of death

67. No post-mortem examination was carried out and the Coroner accepted the cause of death as metastatic lung cancer. COVID-19 pneumonia was listed as having contributed to but not causing his death.

Findings

Clinical Findings

68. The clinical reviewer concluded that the clinical care that Mr Suttie received at Littlehey for his long-term conditions and palliative care needs was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

Management of Mr Suttie's risk of infection from COVID-19

69. The clinical reviewer also found that Mr Suttie was appropriately shielded at Littlehey during the pandemic in line with national guidance. Infection control procedures appeared to be followed at the prison and clinical staff reported no concerns about PPE or the processes for the management of COVID-19 positive patients. Mr Suttie appears to have contracted COVID-19 either in hospital or at the hospice as he had not been in prison for the three weeks before he tested positive.
70. The clinical reviewer did, however, have some significant concerns about some aspects of Mr Suttie's care, which are set out below.

Safe transfer of care

71. The clinical reviewer found that when Mr Suttie returned to Littlehey from hospital on 3 February, there was a failure in the handover and transfer of care procedures between prison healthcare staff, prison staff and the ambulance crew.
72. The clinical reviewer said that Littlehey's information sharing systems failed at multiple points during the hospital discharge process.
73. Mr Suttie's clinical records show that Hinchinbrooke Hospital told prison healthcare staff that Mr Suttie was being discharged to the prison on 3 February. Healthcare staff told us that this information was shared with a prison manager. However, we found no evidence it was shared with J Wing staff or that if it was, the information was acted on, and staff on J Wing said that they did not know in advance that Mr Suttie was returning.
74. We were told that hospital discharges were discussed daily at the healthcare team meeting. However, we found no evidence that Mr Suttie's discharge was discussed. If it was, again, the information was not acted on.
75. When the ambulance carrying Mr Suttie arrived at the prison at around 1.40pm, the gate staff did not contact J Wing or the healthcare unit to inform them that Mr Suttie had arrived, as they should have done. When Mr Suttie returned to J Wing, prison staff were not clear about who to contact. In interview we were told that it was the responsibility of managers on the wing to notify prison healthcare staff of a prisoner's return from hospital, but it appears no-one from J Wing contacted the healthcare unit as they should have done.
76. The ambulance crew took Mr Suttie to his cell and put him to bed. This was not observed by wing staff. However, the bed was set to an unsafe height and the bed guard was not raised. This created a falls risk for a man who had a known

history of falls. We have been unable to obtain the ambulance log records so we do not know what the ambulance staff told prison staff during their handover.

77. An officer said in his written statement he took the hospital discharge paperwork to the healthcare office once Mr Suttie was in his cell. Although the officer did not say whether he handed the paperwork to a healthcare staff member, we were told that if the healthcare office was unmanned, prison staff posted discharge paperwork under the door. The clinical reviewer found this was a significant risk and undermined the transition of care.
78. In interview, the Clinical Manager, the nurse and HCA A all said that healthcare staff did not know that Mr Suttie had returned to the prison. HCA A said that she was the only person in the healthcare office that afternoon, and that she did not receive any hospital discharge paperwork and was not aware of Mr Suttie's return to the prison. However, BWC footage when Mr Suttie was found dead shows HCA A saying that Mr Suttie's paperwork and DNACPR were on the duty desk in the healthcare centre. At interview, HCA A said she did not remember saying this. We consider that this was another missed opportunity to support and assess Mr Suttie.
79. These failures meant that prison healthcare staff did not see Mr Suttie following his return to J Wing, as they should have done, and healthcare staff therefore failed to assess his physical health needs, including medication, or his safety.
80. This resulted in a number of safety and care issues. No one noticed that Mr Suttie was left in a raised bed without bed rails although he was an identified falls risk. He subsequently fell from his bed sometime between 2.10pm and 3.10pm (although we cannot be sure if he was alive when he fell). No one noticed that he was not wearing his Vibby falls monitor, and it would not therefore have triggered when he fell from the bed. Also, no one noticed that Mr Suttie was naked under the bedding. Mr Suttie was terminally ill and it was winter. It is unclear when or by whom the hospital gown, in which he was discharged, was removed. These failures meant that Mr Suttie was not safe in his cell when he returned from hospital.
81. The clinical reviewer found that there was no local Transition of Care policy in place at Littlehey which would have set out information sharing systems and processes.
82. On 4 February, following Mr Suttie's death, a prison operational manager wrote to custodial managers setting out the actions they must take when a prisoner returns from hospital:

"Inform health care that the resident is returning and give details of when he is expected back, explore any concerns over return and cell location. Instruct the gate to inform you when he is back and then inform health care when he arrives.

Check to see if the resident is under social care and inform them of the expected time arrival and explore any specific issues around his care.

Explore with Health care and social care the need for them to be present when he arrives back in his cell."

83. The clinical reviewer said that this guidance for wing staff is helpful and should form part of a local Transition of Care policy. However, she said the policy should also cover the responsibilities of healthcare and other prison staff, as well as formal information sharing processes, the assessment of clinical and care needs, observation checks, the use of safety equipment, and escalation processes.

84. We recommend:

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 checks/observations;**
 - **the use/reconnection of key safety equipment (such as a falls monitor); and**
 - **escalation procedures; and**
- **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.**

The Head of Healthcare should share this report with HCA A and discuss the Ombudsman's findings with her.

Falls assessment and prevention

85. Mr Suttie had been identified as a falls risk on 21 December 2020. A falls assessment referral was made on 22 December. Mr Suttie was admitted to hospital on 23 December and did not return to the prison until 28 January 2021. No falls assessment was completed by prison healthcare staff when he returned. The Head of Healthcare could not explain why this had not been done. This was an omission of care.

86. To help prison staff respond promptly if Mr Suttie fell, social care staff in the prison requested a Vibby falls detector for him (this would detect a fall and send an alert to staff, and also had a button that Mr Suttie could press for help). They told us that the falls detector was in place on 28 January when he returned from the hospice.

87. When Mr Suttie returned from hospice on 28 January, prison staff opened the welfare log as they had been told by social care staff that Mr Suttie could not press his emergency fall bell. Although this was a beneficial additional safety measure, Mr Suttie was unable to reach his cell bell and therefore still needed his

falls detector to alert staff in case he fell or needed help between the hourly welfare checks.

88. However, the OSG who found Mr Suttie on the floor on the evening of 2 February, said she did not think she was alerted by an alarm. In addition, his Vibby detector was not on his wrist or around his neck when he was found dead on the floor on 3 February. It is unclear who removed it and when. Without the falls detector, staff were not alerted when Mr Suttie fell and were therefore not able to respond promptly.
89. We are also concerned that prison staff on J Wing had only limited knowledge of Mr Suttie's falls risk and the equipment that had been provided to alert them to a fall. Wing staff we interviewed were aware of falls detectors and how they worked, but did not know Mr Suttie had one.
90. The Head of Healthcare told us that, since Mr Suttie's death, healthcare staff have been working closely with prison officers on J Wing to provide training and awareness about specific risks, such as falls, and how to manage them until healthcare arrive. The clinical reviewer said that this is extremely good practice.
91. However, she was concerned that there is nothing on the wing to tell prison and healthcare staff at a glance who is a potential falls risk or who has a DNACPR in place, and that this could lead to significant delays.
92. We recommend:

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.

The Governor and the Head of Healthcare should consider how best to share important information about a prisoner's care (such as prisoners identified as falls risk and/or with active DNACPR forms) so that it is easily and readily accessible to prison staff and healthcare staff.

Safeguarding

93. Following Mr Suttie's death, prison healthcare staff raised a safeguarding referral with the local authority in relation to Mr Suttie being discharged from hospital wearing only a hospital gown and that the ambulance crew had put him to bed in an unsafe way, given he was a falls risk. The local authority closed the safeguarding referral without investigating. They noted that there was no clinical reason why Mr Suttie would have had his clothes removed in hospital.
94. We share the clinical reviewer's concerns that Mr Suttie – an elderly man with terminal cancer – was left in an unsafe situation when he returned from hospital. We are also concerned that this is now the third occasion we know of since March 2020 when an elderly prisoner was left in unsafe conditions at Littlehey.
95. Littlehey has a local safeguarding lead and the local safeguarding policy that is being reviewed. This review will take into account the requirements of PSI 16/2015.

96. We expressed concerns about safeguarding in a previous investigation at Littlehey in 2020 and again in relation to the death of a prisoner in March 2021, shortly after the death of Mr Suttie. We consider that collaboration between prison and healthcare staff is required to ensure that a local safeguarding strategy can be developed in line with national expectations. We repeat the recommendation we made following the death in March 2021:

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; and**
- **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.**

97. We also recommend:

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 (eg falls detectors) and the lack of local authority investigation of the safeguarding referral made by the healthcare team.

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.

Non-clinical Findings

98. Mr Suttie's clinical records show that nursing staff at St John's Hospice believed that prison escort staff on duty on the night of 27/28 January were asleep in Mr Suttie's room. It not clear whether this was raised with prison managers at the time. There is no mention of this interaction between the nurse and prison staff in the bed watch log for 27/28 January.
99. While this issue does not relate directly to Mr Suttie's death, it is a serious allegation. We therefore make the following recommendation:

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.

**Prisons &
Probation**

Ombudsman
Independent Investigations