Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Brown, a prisoner at HMP Littlehey, on 14 March 2021

A report by the Prisons and Probation Ombudsman

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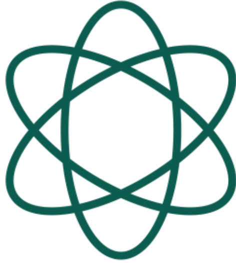
Our vision

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

OGL

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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 Alan Brown died in hospital of COVID-19 pneumonitis on 14 March 2021, while a prisoner at HMP Littlehey. Mr Brown was 77 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that, overall, the clinical care that Mr Brown received at HMP Littlehey was good and equivalent to that which he could have expected to receive in the community. Mr Brown had severe heart failure, prostate cancer and Chronic Obstructive Pulmonary Disease (COPD) and was therefore at risk of serious complications if he contracted COVID-19. He tested positive for COVID-19 on 23 February but, although he appears to have contracted the virus in prison, the clinical reviewer was satisfied that appropriate measures had been taken to protect prisoners, especially those considered to be clinically vulnerable.

However, we are very concerned that prison staff left Mr Brown sitting on the toilet in his cell for 14 hours on the night of 1/2 March. The following morning, he was taken to hospital with suspected hypothermia and sepsis. Although we cannot say whether this contributed to his death, we consider that the fact that an elderly man, who was known to be ill, was left on the toilet all night raises serious safeguarding concerns.

We raised serious concerns about safeguarding at Littlehey in a previous investigation into a death that took place in March 2020, and which also raised issues about the overnight monitoring and care of prisoners.

It is therefore very worrying to see a second 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.

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
Deputy Prisons and Probation Ombudsman **March 2022**

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Summary

Events

1. Mr Alan Brown was sentenced to 17 years custody in December 2016. He had several long-term health needs including Chronic Obstructive Pulmonary Disease (COPD), heart disease and prostate cancer. He transferred to HMP Littlehey in October 2019.

2. On 23 February and 28 February 2021, Mr Brown went to hospital following a fall in his cell. While in hospital on 23 February, he tested positive for COVID-19 and was isolated on his return to the prison later the same evening. On 28 February, a senior manager instructed staff to conduct and record two-hourly welfare observations on all prisoners with COVID-19.

3. After his fall on 28 February, prison staff did not go into Mr Brown's cell to check for injuries as he had COVID-19 but called an ambulance. Other staff later went in to try to keep him warm.

4. On the night of 1/2 March, night staff checked Mr Brown every two hours and recorded that he had been sitting on his toilet continuously from 5.00pm. When day staff came on duty at about 7.30am on the morning of 2 March, they found Mr Brown still sitting on his toilet, cold, very confused and unable to stand. They radioed for healthcare assistance and an ambulance was called at 8.11am.

5. When the paramedics arrived, they told staff that they would make an adult safeguarding referral because of their concerns about the circumstances in which Mr Brown had been found. The prison's Clinical Manager also completed an adult safeguarding referral and asked the Governor to commission a disciplinary investigation to find out why Mr Brown had been left on the toilet all night.

6. Mr Brown was taken to hospital with suspected hypothermia (abnormally low body temperature) and sepsis. He died in hospital on 14 March from COVID-19 pneumonitis. COPD did not cause but contributed to his death.

Findings

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

7. While she could not be sure how or where Mr Brown contracted COVID-19, the clinical reviewer was satisfied that Littlehey took appropriate steps to manage the risk of prisoners contracting the virus.

Overnight welfare checks

8. We are extremely concerned that staff observed Mr Brown sitting on his toilet for 14 hours without intervening.

9. We are also concerned that, despite the provision of PPE, there was reluctance by some staff to go into a prisoner's cell if he had tested positive for COVID-19. We do not consider that the welfare checks conducted through the cell door were adequate

to assess Mr Brown’s welfare, either when he fell in his cell in the early hours of 28 February, or when he was seen on the toilet for 14 hours on the night of 1/2 March.

10. We commend the prompt and compassionate actions of Officer A and CM B.

Safeguarding

11. Littlehey has a local safeguarding policy dated 2019. However, we are very concerned that Littlehey does not have a safeguarding lead. Contrary to Prison Service Instructions, no one that was interviewed for our investigation had awareness of or had completed adult safeguarding training.

The internal investigation

12. We are surprised by the findings of the prison’s internal investigation into Mr Brown’s care overnight on 1/2 March.

Clinical care

13. The clinical reviewer concluded that the clinical care Mr Brown received in prison before his death was of a good standard and equivalent to that which he could have expected to receive in the community. However, we share the clinical reviewer’s concerns about the response to Mr Brown’s falls: healthcare staff failed to undertake a fall risk assessment after the first fall, and prison staff did not inform healthcare staff about the second fall and hospital admission.

Recommendations

- The Governor should ensure that all staff understand the purpose of welfare checks, the need to obtain a response from prisoners if there are any concerns, and the need to escalate concerns promptly.
- The Governor should share this report with Officer A and CM B, so they are aware of the Ombudsman’s comments.
- 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 should:
    - share this report with CM A and discuss the Ombudsman’s findings with him personally; and
    - share this report with OSG A and arrange for a senior manager to discuss the Ombudsman’s findings with him.

- The Head of Healthcare should ensure that a falls risk assessment is completed in line with the SystmOne template when a prisoner has a fall.
- The Governor should ensure that healthcare staff are notified when a prisoner has a fall and /or is taken to hospital.

The Investigation Process

14. 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.

15. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.

16. The investigator met the prison Governor and interviewed six members of staff at HMP Littlehey on 9 June. The Assistant Ombudsman joined the initial meeting with the Governor and three interviews with staff.

17. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison. The clinical reviewer joined the investigator at Littlehey on 9 June for all staff interviews.

18. We informed HM Coroner for Cambridgeshire of the investigation. The coroner gave us a copy of the post-mortem examination results. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Brown's next of kin, his son. Mr Brown's son requested a copy of the report and asked the following questions:

    - How did Mr Brown get COVID-19?
    - Why were Mr Brown's family not told he had COVID-19?
    - Why was there a delay telling Mr Brown's family he was in hospital?

    These issues have been addressed as far as possible in the clinical review, or in this report.

20. 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.

21. Mr Brown's family received a copy of the draft report. They did not make any comments.

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

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. They reported that there had been concerns about ongoing heating and hot water failures, impacting significantly on older prisoners, but that the governor and senior management team had made positive progress in repairing and replacing these systems.

Previous deaths at HMP [Prison]

27. There were 24 deaths at Littlehey in the two years before Mr Brown's death. Twenty-three of the previous deaths were from natural causes (five of which were related to COVID-19) and one was self-inflicted. Since Mr Brown died, there have been five deaths from natural causes, two of which were related to COVID-19.

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. An adult safeguarding referral was made for another prisoner in September 2020, whose death is still subject to PPO investigation.

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 16 December 2016, Mr Alan Brown was sentenced to 17 years in prison for sexual offences and went to HMP Norwich. He was transferred to Littlehey in October 2019 to be nearer to his family.

37. Mr Brown had several long-term health conditions and was hearing impaired. He was diagnosed with COPD in 2016 and severe heart disease in 2017. Mr Brown was also diagnosed with prostate cancer and was added to the cancer and palliative care register as soon as he transferred to Littlehey.

38. On 14 April 2020, Mr Brown was identified as clinically extremely vulnerable to serious complications if he contracted COVID-19 and was advised to shield in line with government guidance. He agreed to do so and was appropriately located on a prison shielding unit.

39. On 23 April, Mr Brown was issued with a DNAR (Do Not Attempt Resuscitation) wristband by the Nurse Manager, who signed to say that he had agreed to wear it.

40. On 24 April, Mr Brown had a virtual review of his COPD management plan and was given a rescue medication pack as he was shielding. (A COPD rescue pack contains steroids and anti-inflammatory medication so that he could start treatment immediately if his symptoms worsened.)

41. On 9 June, Mr Brown tested negative for COVID-19 before a hospital appointment. There are no other routine COVID-19 tests recorded in his records.

42. Mr Brown attended his cancer reviews at hospital on 29 June and 8 September. His original appointment in March was cancelled due to COVID-19. He was referred for an MRI scan, but did not go to his appointment on 24 September or 7 October as he was worried about catching COVID-19. He asked that he be offered a further appointment when the pandemic was over. The prison GP confirmed that this appointment could be rescheduled to January 2021.

43. In November, Mr Brown was again advised to shield in line with government recommendations and, again, he did so. His DNAR status was also confirmed and recorded in his medical records.

44. On 12 January 2021, a nurse recorded that she could not complete a medical screen appointment with Mr Brown as he could not hear her, even with her voice raised. Mr Brown told the nurse that he had particular trouble hearing her because his hearing aid was dirty, and she was wearing a face mask. The screening was postponed, and he was referred for a hearing appointment. The same day, the prison wrote to him advise him to continue to shield and he agreed to stay on the shielding wing.

45. Mr Brown received his first COVID-19 vaccination on 16 February and was due to have his second vaccination on 11 May. He had no COVID-19 symptoms at the time of his first vaccination.

February 2021

46. On 23 February, Mr Brown was found on his cell floor by a prison GP, who was visiting another prisoner. He was helped back to bed and a nurse and the GP reviewed him later that day. They arranged for an urgent transfer to hospital because Mr Brown had chest pain and shortness of breath.

47. Mr Brown tested positive for COVID-19 in hospital and went back to prison that night, where he began a 14-day isolation period. There were no prison healthcare staff on duty when he got back to prison. The next morning, a nurse recorded his temperature and oxygen, but she did not complete a falls risk assessment, as required by national guidance.

48. Mr Brown was given equipment to monitor his own oxygen saturation levels in his cell and was told to inform healthcare if his levels dropped below 94%.

49. On 28 February, an Operational Support Grade (OSG) recorded that during the morning roll check (at about 5.45am), she found Mr Brown had fallen onto the floor of his cell. (Accounts vary as to how long Mr Brown had been lying on his cell floor, but he told an officer that he had been there from 2.00am until he was found by staff.) The OSG did not go into the cell but contacted the night duty manager, Custodial Manager (CM) A.

50. CM A looked through the cell observation panel but did not go into Mr Brown's cell. He called an ambulance at 6.26am as there were no healthcare staff on duty. The investigator listened to CM's call to the Ambulance Service. He told the operator that they had not opened Mr Brown's cell door because he had tested positive for COVID-19. The operator instructed him not to move him in case he had injuries.

51. Officer A came on duty at about 7.00am and was told Mr Brown was on the floor waiting for an ambulance. She put on PPE and, together with a senior manager and another CM, she went into the cell to try to check on Mr Brown's welfare and to cover him with a blanket to keep him warm.

52. Paramedics arrived to take Mr Brown to hospital at 7.26am. He was discharged from hospital later that day. Prison staff did not tell healthcare staff about this fall, so no one completed a falls risk assessment and there was no record of the hospital visit in Mr Brown's medical records.

Events of 1 and 2 March

53. Mr Brown was subject to two-hourly welfare checks because he had COVID-19. A trainee officer conducted a roll check (count of prisoners) at about 5.00pm and recorded that Mr Brown was sitting on the toilet in his cell. An officer checked Mr Brown at 6.00pm and 8.00pm, in line with his scheduled welfare checks, and recorded that he was on the toilet. He said that he did not think that Mr Brown was in difficulty and did not speak to Mr Brown. He said that at the end of his shift he gave a verbal handover to OSG A, who was on night duty that evening. The OSG was new to the wing and the officer said he stayed for an extra 15 minutes to explain the wing's fall detector and give him an overview of the wing.

54. Every two hours between 9.05pm and 7.05am, OSG A recorded in the COVID observation log that he had checked Mr Brown. In each entry he noted that Mr Brown was on the toilet and that that he saw him move. He told the investigator that he spoke loudly because the cell door was shut and it was dark, and he said he saw Mr Brown put his thumb up. He said he knew that Mr Brown was hearing impaired as there was an alert sign on his door.

55. OSG A said that he was not concerned about Mr Brown overnight, so he had no reason to contact CM A, the night duty manager, about him. The CM told the investigator that he called and visited the wing during the night and spoke to the OSG, who reported that everything was fine. The CM did not look at Mr Brown's observation log or welfare check records on the evening of 1 March to morning of 2 March.

56. On 2 March, Officer A started her shift at 7.30am. The trainee officer had done the morning roll count and told Officer A that he was worried that Mr Brown had been on the toilet all night. Officer A said she immediately contacted CM B and, together with a senior manager, they went into Mr Brown's cell, wearing full personal protective equipment (PPE). She said that Mr Brown was cold to the touch, very confused and unable to stand.

57. CM B radioed for medical assistance and he and Officer A tried to warm Mr Brown up with hot drinks and extra clothing. Healthcare staff arrived and treated Mr Brown. An ambulance was called at 8.11am. Paramedics assessed Mr Brown and took him to Hinchingbrooke Hospital, where he was admitted with possible hypothermia (a dangerous drop in body temperature) due to exposure and possible sepsis (a severe response to an infection).

58. Mr Brown died at Hinchingbrooke Hospital on 14 March.

Safeguarding referral

59. Paramedics told healthcare staff that they would complete an adult safeguarding referral for neglect because of the circumstances in which they found Mr Brown.

60. On 2 March, the prison's Clinical Services Manager made an adult safeguarding referral to Cambridgeshire County Council and Northamptonshire Healthcare NHS Foundation Trust, in line with policy.

61. The Clinical Services Manager also asked the Deputy Governor to commission an investigation into the events overnight on 1/2 March in response to the safeguarding referrals. The Head of Reducing Reoffending completed the internal investigation at the Clinical Services Manager's request.

Contact with Mr Brown's family

62. On 3 March, an officer was appointed as the prison's family liaison officer (FLO). When he tried to contact Mr Brown's nominated next of kin, his wife, he found that she had recently died. He spoke to Mr Brown's daughter on the telephone that day and told her that Mr Brown had been admitted to hospital and there was a care planning meeting later that day.

63. The FLO updated Mr Brown's family daily as his health deteriorated and facilitated a family visit on 12 March.

64. On 14 March at 6.50am, the FLO called Mr Brown's daughter and informed her that Mr Brown had died. He offered his condolences and support.

65. Mr Brown's funeral took place on 15 May. Littlehey offered to contribute to the cost, in line with national instructions.

Support for prisoners and staff

66. After Mr Brown's death, CM B 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.

67. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

Post-mortem report

68. The post-mortem examination took place on 31 March and found that Mr Brown died of COVID-19 pneumonitis. He also had COPD, which did not cause but contributed to his death.

Findings

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

69. At the outbreak of the pandemic, Mr Brown was identified as at high risk of contracting the COVID-19 virus. He was advised to shield on three separate occasions in line with government recommendations. He accepted the advice and remained on a shielding wing throughout his time at Littlehey.

70. Mr Brown tested positive for COVID-19 on 23 February when he was admitted to hospital following a fall. He had not left Littlehey in the months before this, so it appears that he contracted the virus in prison. The clinical reviewer said that she could not be sure how Mr Brown contracted COVID-19, but she was satisfied that the prison followed the appropriate measures to reduce the risk of prisoners catching the virus.

Overnight Welfare Checks

71. We are concerned that when Mr Brown fell on 28 February, some staff were reluctant to go into his cell because he had COVID-19. The investigator listened to the recording of CM A's conversation with the Ambulance Service and noted that he said he was not going to open the door because Mr Brown had COVID-19. The CM told the investigator that it was not necessary to enter the cell because Mr Brown was talking and moving, and he did not therefore consider it an "extreme emergency". He also said that the PPE had been moved and they did not know where it was, and that "there was not a great deal of PPE on the wing".

72. Staff told us in interview that staff could enter a cell to check on a prisoner if they had significant concerns, providing that they wore full PPE. Officer A and two other staff were able to put PPE on and enter Mr Brown's cell almost immediately both 28 February and on 2 March. Mr Brown was an elderly man with COVID-19 lying on a cell floor in winter and we consider that CM A should have gone into his cell on 28 February to check on his welfare and to try to keep him warm while they waited for an ambulance.

73. Mr Brown was subject to two-hourly monitoring because he had COVID-19. An officer saw him sitting on the toilet at 6.00pm and 8.00pm. We would have expected him to have some concerns about this and to have spoken to Mr Brown to check his welfare on the second occasion. We are concerned that he did not speak to Mr Brown. However, we accept that it is within the bounds of possibility that he could have thought that Mr Brown just happened to be on the toilet both times he checked him and that it did not occur to him that Mr Brown might have been there for two hours.

74. We are very concerned that OSG A did not realise that Mr Brown was ill, despite noting he was on the toilet every two hours for ten hours. The OSG told the investigator that he had seen Mr Brown move and assumed that he had a stomach problem. We consider that whether he thought Mr Brown had a stomach problem or not, he should have realised that it is not normal to sit on a toilet all night and should have been more concerned about the welfare of an elderly man who was known to have COVID-19.

75. CM A said that, as the night duty officer operationally in charge of the prison, it was his responsibility to check ACCT documents and wing observation books, check that staff had been briefed, and respond to any issues on the wings. He said that he would have routinely visited Mr Brown's wing and asked OSG A if there were any concerns. However, he said that he did not look at the welfare checks or COVID observation logs as they are documents designed for wing staff to communicate with health and social care staff working on the wing.

76. We do not accept this. We consider that these are essential means of checking prisoners' welfare overnight when there are no healthcare staff on duty. The whole point of them is to enable prison staff to identify whether a prisoner who has COVID-19 needs medical assistance during the night. We would, therefore, expect the night duty manager to at least check a sample to ensure they were being done. We would also expect him to make clear to the night staff that the welfare checks were not just designed to communicate with healthcare staff when they came on duty but are an important tool for prison staff to satisfy themselves that prisoners are well.

77. Healthcare provision at Littlehey is not 24-hour. The clinical reviewer concluded that existing arrangements for prisoner care and monitoring overnight are sufficient to meet the needs of the prison's population. However, this relies on prison staff identifying healthcare concerns and escalating them appropriately.

78. During their visit to Littlehey on 9 June, the clinical reviewer and the investigator noted that it would have been extremely difficult to see a prisoner sitting on the toilet due to the angle of the cell door window. They also considered that it would have been very difficult for Mr Brown to hear through a locked cell door, given that he was hearing impaired. During interview, Officer A said that she often had to get Mr Brown's attention by physically tapping him on the shoulder as he had such difficulty hearing.

79. We do not think that it was possible to check Mr Brown's wellbeing through the cell door, especially as he was severely hearing impaired. We are also concerned about some staff's apparent reluctance to go into a prisoner's cell if they had tested positive for COVID-19. We make the following recommendation:

    The Governor should ensure that all staff understand the purpose of welfare checks, the need to obtain a response from prisoners if there are any concerns, and the need to escalate concerns promptly.

80. Since Mr Brown's death, healthcare staff have put up several posters on the wing to prompt prison staff to escalate concerns and increase their awareness of the needs of older prisoners. The Head of Healthcare told us that there is ongoing work with NHS England to raise awareness with prison staff of care practice for elderly prisoners. The investigator saw this reference material displayed on prison wings during her visit. However, we are concerned that healthcare staff and prison staff need to work effectively together to meet the needs of the prison population.

81. We commend the actions of Officer A in entering Mr Brown's cell on 28 February and 2 March to check his welfare and to try to make him comfortable, and CM B who did the same on 2 March. They both acted promptly, professionally and compassionately. We recommend:

82. The Governor should share this report with Officer A and CM B so they are aware of the Ombudsman's comments.

Safeguarding

83. Mr Brown was admitted to hospital with possible hypothermia after sitting on the toilet in his cell for around 14 hours. Although we cannot say that this led directly to his death – he was an elderly man with serious health conditions that made him extremely vulnerable to COVID-19 - we are extremely concerned that this was allowed to happen. We consider that it was entirely appropriate for the ambulance paramedics and the Head of Healthcare to raise their serious concerns by making safeguarding referrals.

84. Littlehey does not have a safeguarding lead, or clear safeguarding structure as required by PSI 16/2015. No one interviewed for this investigation had completed adult safeguarding awareness training. We understand that there is currently no mandatory adult safeguarding awareness training for prison staff.

85. We expressed concerns about safeguarding in a previous investigation at Littlehey in 2020. We are aware of two safeguarding referrals being made to the local authority for suspected neglect within the last 18 months. The clinical reviewer was satisfied that healthcare staff followed national safeguarding policy and procedures and made appropriate safeguarding referrals in a timely manner on 2 March. However, we remain concerned about the safeguarding practice of non-clinical staff at the prison.

86. We share the clinical reviewer's view 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 make the following recommendation:

The Governor should:

- **work with the Head of Healthcare 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 internal investigation

87. After Mr Brown's death, the safer custody hub manager commissioned the Head of Reducing Re-offending to carry out a factfinding investigation into the events of 1/2 March. Her investigation report, dated May 2021, concluded:

88. "There is no evidence to suggest staff were negligent in their duties and commissioning of a disciplinary investigation is not needed in this situation".

89. The recommendation from the investigation was that advice and guidance was issued and that a period of re-training was appropriate. We are surprised at the

outcome of her investigation given the findings of our own investigation. We make the following recommendation:

The Governor should:

- **share this report with CM A and discuss the Ombudsman's findings with him personally; and**
- **share this report with OSG A and arrange for a senior manager to discuss the Ombudsman's findings with him.**

Clinical care

90. The clinical reviewer said that the clinical care Mr Brown received at Littlehey was mainly of a good standard and was equivalent to that which he could have expected to receive in the wider community. His long-term health was managed and monitored appropriately.

91. The clinical reviewer was, however, concerned that healthcare staff did not complete a falls risk assessment following Mr Brown's fall on 23 February. We are also concerned that prison staff did not tell healthcare staff about Mr Brown's fall and subsequent hospitalisation on 28 February, so, again, healthcare staff did not complete a falls risk assessment.

    We make the following recommendations:

- **The Head of Healthcare should ensure that a falls risk assessment is completed in line with the SystmOne template when a prisoner has a fall.**
- **The Governor should ensure that healthcare staff are notified when a prisoner has a fall and /or is taken to hospital.**

Contact with Mr Brown's family

92. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic. This also said that if a prisoner is diagnosed with COVID-19, they should be asked if they want to inform anyone.

93. Mr Brown's family were concerned that they were not told when he tested positive for COVID-19. There is no requirement for prisons to notify families when a prisoner tests positive for COVID-19. For most prisoners, COVID-19 is a mild illness, and they can communicate with their families directly. There is, however, no evidence that Mr Brown was asked whether he wanted to inform anyone that he had COVID-19.

94. Mr Brown's family also asked why they were not notified of Mr Brown's hospital admission on 2 March. The prison said that they did not believe that Mr Brown's condition was sufficiently serious to notify his family when he was first admitted to hospital. It was only apparent that Mr Brown was seriously ill on 3 March and his

family were then contacted without delay. We consider that the prison acted reasonably in the circumstances.

Inquest

95. The inquest into Mr Brown’s death was heard on 20 June 2023, with a verdict of natural causes.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2022**

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