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

Mr Sidney Hughes on 24 November 2023 at HMP Wymott

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare at HMP Wymott should carry out an audit to assure themselves that secondary reception screenings are being completed in accordance with guidance, and report back to the Ombudsman within two months.	Accepted	Audit planned to ensure that the reception screen is followed up with a separate secondary screen within 5 days as per NICE Guidance NG57 The audit will be completed within the two-month time scale and a copy will be sent to the PPO.	Head of Healthcare Greater Manchester Mental Health NHS Foundation Trust	June 2024
2	The Head of Hertfordshire Probation Delivery Unit should ensure that Senior Probation Officers are aware of their responsibilities to allocate tasks relating to Early Release on Compassionate Grounds to a duty Community Offender Manager in a timely manner.	Accepted	I have reviewed the investigation with the relevant SPO to ascertain what caused the delay in allocating this OMIC case to a Community Offender Manager. A combination of insufficient information to support allocation and release planning exacerbated by delayed responses from Probation to prison colleague's enquiries regrettably prolonged the execution of this urgent activity. To ensure Senior Probation Officers are aware of their responsibilities in accordance the ERCG Policy Framework and to mitigate the factors	The Head of Hertfordshire Probation Delivery Unit	June 2024

			which contributed to the delay, the following actions will be taken: Summary of investigation findings and recommendations will be delivered via the Hertfordshire Local Quality Matters Board. Learning from this Board will trigger a briefing and, where necessary, a training strategy to ensure Probation managers and staff are familiar with the framework and their role in operating within this. Learning from this investigation will be referred to the OMIC Senior Leadership Forum within the East of England to provide assurance that OMIC handover systems are sufficiently robust, particularly in the context of compassionate early release, to support timely collaboration and outcomes.		