

Action Plan in response to the PPO Report into the death of Mr Michael Higginbottom on 05/06/2022 at HMP Stafford

| Rec No | Recommendation | Accepted / Not accepted | Response Action Taken / Planned | Responsible Owner and Organisation | Target Date |
|--------|--|-------------------------|--|------------------------------------|-------------|
| 1 | The Governor and Head of Healthcare should explore alternative options for meeting a prisoner's care needs when they cannot be met on a standard wing. | Accepted | <ul style="list-style-type: none"> • Social Care Unit Arrangements: A review process is in place to ensure that prisoners who cannot be safely discharged to a residential unit are managed appropriately within the Social Care Unit. • Pathway Development: A clear referral pathway has been established for prisoners with health and social care needs that fall outside HMPPS policy and cannot be accommodated in custody, developed in collaboration with healthcare and external partners. • Safeguarding Policy: Processes for managing concerns about individuals with increased health and social care needs have been reviewed and strengthened | Governor & Head of Healthcare | Complete |

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| | | | <p>under the local safeguarding policy to ensure timely and consistent action.</p> <ul style="list-style-type: none"> • Medication and Risk Sharing: We have communication protocols so that risks associated with medication and elderly or frail prisoners are shared with prison staff. This ensures informed decision-making in the event of an accident, fall, or change in behaviour. Medication-related considerations are now incorporated into falls assessments and communicated effectively to staff. | | |
| | | | <p>HM Prison and Probation Service (HMPPS) is undertaking a review of the Continuity of Care policy, including the threshold for care in custody. The revised policy framework is scheduled to complete in March 2026.</p> | HMPPS | March 2026 |
| | | | <p>Additionally, joint working between HMPPS, NHS England and ADASS (Association of Directors of Adult Social Services) is underway to develop and implement a National Allocation Process to improve access to adapted and to agree a national approach to the development and operation of specialist accommodation for those with health and social care needs.</p> | HMPPS | March 2026 |

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| 2 | The Head of Healthcare should ensure that the falls assessment includes a procedure for patients who are prescribed blood-thinning medication based on the National Institute for Health and Care Excellence (NICE) Head Injury guidance. | Accepted | <p>Falls template was reviewed and all staff completed internal training on the completion and escalation (June 2022). An audit was completed October 2022 providing assurance of compliance. On review it was highlighted that the template does not include outcomes as there is no longer a community falls team, this has been escalated to the Regional and National Team.</p> <p>Onsite local process in place where identified risk markers are added to the Patients clinical medical records home page to prompt staff to transfer to Accident and Emergency following a confirmed fall / suspect head injury. High risk patients are also annotated on the daily handover form (March 2023).</p> | Head of Healthcare | Complete |
| 3 | The Head of Healthcare should ensure that when healthcare staff complete vital observations, they use the NEWS2 scoring system as a standard procedure. | Accepted | <p>NEWS2 scoring calculation and escalation is mandatory for all staff. Completion and competencies are held on the Electronic Learning Module System (LMS) and monitored monthly for staff compliance. Prompt cards are on all monitors and held within the Emergency bags.</p> <p>Incident reports are reviewed and where staff highlighted not to have completed an individual training plan is put in place to improve compliance.</p> | Head of Healthcare | Complete |

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| 4 | The Head of Healthcare should engage with a senior clinical hospital colleague in order to improve the discharge information process between the hospital provider and HMP Stafford. | Accepted | Regional Governance Lead has communicated with the hospital trusts to improve discharge documentation. Where appropriate discharge paperwork has not accompanied a patient this is incident reported and monitored through the Local Delivery Board. | Head of Healthcare | Ongoing |
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