

Action Plan in response to the PPO Report into the death of Stephen Brown on 06/09/2021 at HMP Durham

| Rec No | Recommendation | Accepted / Not accepted | Response Action Taken / Planned | Responsible Owner and Organisation | Target Date |
|--------|--|-------------------------|--|------------------------------------|-------------|
| 1 | The Head of Healthcare should ensure that staff are aware of NICE guideline Hypertension in adults: diagnosis and management. | Accepted | <p>Training sessions remain in place to educate all clinical staff regarding NICE guideline Hypertension in adults: diagnosis and management. A record of training is maintained to evidence compliance.</p> <p>There is a competency assessment that works along this to ensure compliance with how to take and record and blood pressure, and escalation of abnormal readings.</p> <p>There is a flowchart which advises at a glance the management of an abnormal blood pressure reading.</p> | Spectrum Community Health CIC | Complete |
| 2 | The Head of Healthcare should ensure that reception nurses routinely review the outcome of the physical observations taken by the healthcare support | Accepted | <p>The report and recommendations have been shared with all clinical staff and lessons learnt are discussed in local Quality management meetings (February 2022).</p> <p>This action has also been discussed as part of</p> | Spectrum Community Health CIC | Complete |



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| | workers. | | reception screening and NEWS2 training in relation to reviewing of clinical observations, regardless of the situation they were taken. | | |
| 3 | The Head of Healthcare should ensure that there is a clear escalation process in place where a healthcare support worker records any clinical observation that is not within expected parameters. | Accepted | <p>Training sessions remain in place to educate all clinical staff regarding NICE guideline Hypertension in adults: diagnosis and management. A record of training is maintained to evidence compliance.</p> <p>There is a competency assessment that works alongside this to ensure compliance with clinical monitoring and escalation.</p> | Spectrum Community Health CIC | Complete |
| 4 | The Head of Healthcare should explore why the reception GP was unable to access the Summary Care Records on 31 August 2021 and initiate a process to avoid a future reoccurrence. | Accepted | <p>This action has been escalated to the Associate Medical Director as part of the Reception GP's clinical supervision.</p> <p>It has been established that the GP overlooked the summary care record information in this instance.</p> <p>A reflective learning review was completed in order to learn lessons from this case (March 2022).</p> | Medical Director | Complete |
| 5 | The Head of Healthcare should ensure that all staff are reminded of Standard Operating Procedure Reception and Treatment Pathway for Substance Misusers in the North East Prisons and that full clinical observations are taken | Accepted | <p>Training sessions remain in place to educate all clinical staff regarding the Substance Misuse clinical pathway Standard Operating Procedure. A record of training is maintained to evidence compliance.</p> <p>There is a competency assessment that works</p> | Spectrum Community Health CIC | Complete |



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| | <p>and recorded for prisoners being monitored for alcohol withdrawal symptoms.</p> | | <p>alongside this to ensure compliance with clinical monitoring and escalation.</p> <p>Clinical supervision is also in place to support any case study discussions.</p> | | |
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