

# Action Plan in response to the PPO Report into the death of Mr Mark Stewart Park on 17/08/2021 at HMP Northumberland

| Rec No | Recommendation   | Accepted / Not accepted | Response Action Taken / Planned   | Responsible Owner and Organisation | Target Date |
|--------|--|-------------------------|---|------------------------------------|-------------|
| 1      | The Head of Healthcare should review the system of referrals to long-term conditions clinics and ensure these are implemented and completed in line with NICE clinical guidance. | Accepted                | Protected time (2 days per week) has been established for Long Term Conditions intervention (LTC). The need for a specialist nurse was identified and the role is now in place.<br><br>There will be further developing of the LTC referral pathway, ensuring regular audit of the pathway and interventions by the Clinical Lead. This will ensure LCT service remains in line with NICE guidance. | Head of Healthcare                 | 30/4/22     |
| 2      | The Head of Healthcare should ensure that processes are in place for all prisoners to have a secondary reception/transfer screen and to allow for appropriate long-term planning | Accepted                | The secondary screening process is currently under review with a view to ensuring that all prisoners receive both a first and secondary screening in a timely manner and in accordance with NICE guidance. Regular audit will be conducted by the Clinical Lead to  | Head of Healthcare                 | 30/4/22     |



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|   | for prisoners, in line with NICE guidance NG 57.   |          | ensure that long term conditions are identified and appropriately directed to the LTC service.  |   |           |
| 3 | The Head of Healthcare should ensure that healthcare staff initiate care plans in a timely manner following identification of a health need to allow for timely individualised care.   | Accepted | <p>A process is being developed to ensure a care plan is initiated whenever a clinical condition is identified.</p> <p>A regular audit of the existence and quality of individual care plans will be carried out through clinical supervision.</p> <p>Regular audit of the quality-of-care plans will be carried out through the random selection and analysis of care plans across the healthcare service.</p> | Head of Healthcare  | 30/4/22   |
| 4 | The Director should ensure that all prison staff understand their responsibilities during medical emergencies and ensure staff use an emergency medical code promptly to communicate the nature of an emergency effectively. | Accepted | PSI 03/2013 will be reissued via our community notice communication process. Night Orderly Officers will also be fully briefed by their line manager to provide an assurance they understand the process of medical emergency codes and that all night staff are briefed accordingly.   | <p>Director</p> <p>Deputy Head of Security and Safety</p> | Completed |



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|   |   |          | The Night Operation Support Officer group, who are normally first on scene, will receive a specific refresher on their understand of the emergency codes and how they are activated/used. This is also to include clear direction as to their individual responsibilities |  |               |
| 5 | The Director should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them. | Accepted | The Deputy Head of Security and Safety will ensure that the staff mentioned within the Ombudsman's report, are contacted, and taken through the findings and recommendations.   | Director<br><br>Deputy Head of Security and Safety | February 2022 |

