

Action Plan in response to the PPO Report into the death of Mr Lawrence Gray on 27/01/2022 at HMP Wealstun

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should ensure that patients suffering from low blood sugars are reviewed with an appropriate timescale to support with ongoing assessment and documentation within the SystmOne records.	Accepted	<p>Patients with low blood sugars are assessed and reviewed routinely. All documentation from Healthcare assessments is recorded on SystmOne.</p> <p>From 25/08/2022, patients reporting to have abnormal blood sugar readings are placed on the wing ledger and seen the same day by Hotel1</p>	Head of Healthcare	Complete
2	The Head of Healthcare should ensure that patients with diagnosed Long Term Conditions are referred into appropriate clinics through the reception screening template and in line with NICE Guidance NG57 Physical Health of People in Prison.	Accepted	<p>Patients should be identified as having a long term condition during the healthcare reception screening. Patients will then be booked into the relevant clinic for review/treatment.</p> <p>From 25/08/22, a Long Term Conditions clinic is to be held every Wednesday am every 4 weeks; waiting list for patients is maintained through the electronic clinical record alongside review of the Quality and Outcomes Framework register.</p>	Head of Healthcare	Complete



3	The Head of Healthcare should ensure that care planning is initiated and reviewed as appropriate for patients with Long Term Conditions.	Accepted	<p>Process in place for care plans to be initiated and reviewed and regular intervals. Long term condition lead nurse appointed.</p> <p>From 25/08/22- Long term condition clinics planned every 4 weeks with time allocated in the afternoon to complete care plans. This will be reviewed after 2 months with the possibility of moving this to 2-weekly, if necessary.</p>	Head of Healthcare	
4	The Governor should commission an investigation into allegations that prison bedwatch staff were asleep while on duty on the night of 18 December 2021, with a view to considering whether disciplinary action is appropriate.	Accepted	Management Inquiry completed in August 2022. As a result disciplinary action was not deemed appropriate. The recommendation from the Inquiry, of updated instructions to staff to be placed in the bed watch documentation that outlines instructions to staff, has been implemented.	Governor	24/10/22

