

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

Mr Anthony Noble on 08 May 2022 at HMP Preston

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 carry out a mental capacity assessment during the reception screening process if a prisoner arrives with signs of dementia or confusion.	Accepted	<p>Head of Healthcare has produced a pathway to ensure patients are signposted correctly. The health needs pathway on reception also ensures information/risk sharing across the wider establishment/multi-disciplinary team.</p> <p>A Neuro diversity pathway, which includes a Dementia pathway is in place for patients who enter reception (ND pathway-IMHT).</p> <p>Safety questions are introduced at handover, one of which asks, "have there been any patients that have presented as confused" - if yes "what actions taken" (assurance check).</p>	Head of Healthcare/Spectrum	31/11/2022
2	The Head of Healthcare should ensure that staff assess older prisoners' risk of falls during the reception screening process.	Accepted	A Falls Lead and Frailty Lead has been identified. The Falls and Frailty pilot has taken place and is now being fully embedded into care.	Head of Healthcare/Spectrum	31/02/2023



			All staff to receive in house falls training sessions to ensure that they correctly refer and identify those at risk of falls.		
3	The Head of Healthcare should complete an audit on the use of care plans within HMP Preston.	Accepted	<p>Care plans to be audited monthly to ensure patients have relevant care plans in place and have been reviewed. A senior practice Nurse is now in post and a clinical coder to enhance this process.</p> <p>Contact has been made with the system 1 lead to understand how a report can be produced to view care plans due for review daily and to embed a review process into daily service delivery.</p>	Head of Healthcare/Spectrum	<p>Complete</p> <p>31/03/2023</p>

