

Action Plan in response to the PPO Report into the death of Mr Stephen Hotson on 09/10/2021 at HMP Dovegate

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should ensure that all prisoners with a chronic health condition have a patient involved management of care and treatment plan as per NICE guidance.	Accepted	A local operating procedure was implemented in March 2022 which identifies patients with complex needs and ensures that the needs of the patient's health and wellbeing are met whilst in our care.	Head of Healthcare	Complete
2	The Head of Healthcare should investigate why the change in hypertensive medication was not monitored by nursing staff or GPs in the three months prior to Mr Hotson's death.	Accepted	<p>This has been investigated, and when he was started on Ramipril in May 2021 his BP was checked 16 times over 4 months. Systems were in place to monitor BP and task message the prescribers.</p> <p>It is evident from the medical records that BP monitoring checks were completed on 21/7/21 and 27/7/21. BP was also monitored 5/8/21 and patient reviewed by GP. The GP changed his antihypertensive medication to Losartan on 5/8/21 after the patient did not tolerate the higher dose of Ramipril.</p> <p>Patient DNA'd appointment on 20/8/21 for blood test monitoring.</p>	Head of Healthcare	Complete



			<p>Further monitoring was attempted on 23/8/21 - this is recorded as a no access visit.</p> <p>The patient passed away on 9th October 2021. His BP was monitored on 5.8.21 - 9 weeks prior to his death. Further attempts were made to monitor the blood pressure, although these were not completed. The patient was booked in for a review with the GP on 21/10/21, 11 weeks after his medication was changed, but unfortunately, he passed away before this appointment was facilitated.</p>		
3	<p>The Head of Healthcare should investigate why Mr Hotson did not take prescribed medication of metformin for almost three years before this was discovered.</p>	Accepted	<p>This has been investigated, and it is evident from the Doctor's entry in the records on 14/02/18 that a discussion was had with the patient.</p> <p>The entry states metformin daily for 14 days, then increase to 2 times daily. The patient chose to stop taking his metformin as he reported it was making him ill in 2017 - this was discussed with the GP 13/12/17 and 28/12/17. His diabetic bloods continued to be monitored. His abdominal symptoms did not resolve, and he was referred to a specialist. He restarted his metformin in May 2018, but then chose to stop again, without giving any reason. Again, his blood monitoring was continued. In January 2019, the patient informed the GP that he was not taking any medication except lansoprasole. He was referred for HBA1c blood tests and an USS.</p> <p>In February 2019 the HBA1c came back in the borderline range at 43.2 and another GP saw the result and noted that no further action was necessary. Indeed, over the following year he was overweight but not obese. There were dietary</p>	Head of Healthcare	Complete August 2022



			<p>options and choices available so it would be acceptable to control Type II diabetes by diet alone in those circumstances. In February 2020, a GP interpreted an HBA1c level of 53 as being good diabetic control. The target HBA1c level is usually 53 for a patient on Metformin, although this can be an individually agreed threshold. However, he had stopped taking Metformin in June 2018.</p> <p>In March 2021 the ANP reviewed his bloods, and advised the patient that he needed to restart his metformin. The patient took this advice, and restarted the metformin, and continued to take until he passed away. There is nothing in the medical records to indicate why the patient chose to stop ordering or taking his metformin between 12th June 2018 and March 2021.</p>		
4	The Director should ensure that there is appropriate cover over the lunch period for staff to respond to cell bells and that all cell bells are answered within five minutes.	Accepted	<p>Residential COMs have been reminded of their responsibilities to ensure a PCO is covering cell bells during patrol periods.</p> <p>A notice to staff has been issued regarding the expectation that cell bells are answered within 5 minutes.</p> <p>The Cell bell policy has been reviewed and amendments have been made to the data analysis process. QA processes have been implemented to ensure staff are adhering to the instructions.</p>	Assistant Directors of Residential and Safety	<p>April 2022</p> <p>May 2022</p>
5	The Director should ensure that staff switch on their body-worn video cameras (BWVCs) at the earliest	Accepted	Following a review of the incident the Director issued a notice to colleagues on 1/11/2022, reminding them on the	Assistant Director of Safety	November 2022



	opportunity during any reportable incident.		importance of using and deploying a Body Worn Video Camera at the earliest opportunity during an incident.		
--	---	--	--	--	--

