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

Mr Sean Dougherty on 1 September 2019 at HMP Bailiwick of Guernsey – updated 16 February 2023

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare and the Lead GP should consider carrying out an internal investigation to establish: • Why hospital staff did not forward the results of the CT scan carried out on 12 February 2018 in order to update the prison GP	Accepted	The Quality and Patient Safety Department of Health and Social Care will review with the Clinical Director implementation of a Serious Incident Review for incident number 65453	HSC Quality and Patient Safety	12 August 2022 Completed Additional external review by MSG
	• Why Mr dougherty was not referred to the Regional Vascular Service for ongoing monitoring of his abdominal aorta aneurysm • Why, following the result of the CT scan carried out 12 February 2018, there was no evidence of correspondence between hospital staff and healthcare staff • Why healthcare staff did not contact hospital staff to find out results of the CT scan on 12 February 2018	Accepted	The Serious Incident Review will take into consideration the information and recommendations provided in the Ombudsman Report for application from a learning perspective	HSC Quality and Patient Safety	30 October 2022 Completed recommendations made to MSG

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2	The Head of Healthcare should agree a system of communication between Princess Margaret Hospital and Guernsey Prison to ensure prisoners' continuity of care.	Accepted	The Serious Incident Review will take into consideration the information and recommendations provided in the Ombudsman Report for application from a learning perspective – **NB it is princess Elizabeth not Margaret**	HSC Quality and Patient Safety	30 October 2022 Measures put in place, NFA
3	The Head of Healthcare should ensure that: • if a prisoner attends a secondary care appointment or procedure, clinical correspondence is followed-up; and • if correspondence is not received from secondary care providers in a timely manner, this should be escalated to the healthcare commissioners.	Accepted	The Serious Incident Review will take into consideration the information and recommendations provided in the Ombudsman Report for application from a learning perspective		

4	Head of Healthcare should implement an electronic system in order to record prisoner’s medical history	Not Accepted as there is currently an ePR Prison Health care staff can access and use with a new ePR scheduled for introduction in Quarter 4 of 2023	All areas of Health and Social Care, of which the Prison Healthcare Centre belongs, has access to the Princess Elizabeth electronic patient record - TRAK The review cited above will take this into consideration and review why the EPR was not accessed and appropriate follow up not undertaken. Access to an ePR is currently being reviewed by the Business Development Team and the QIM in consultation with the Prison Healthcare Manager		