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

Mr Edward McCulloch on 25/06/2021 at HMP Isle of Wight

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 use a coordinated care plan approach to manage long-term conditions, and accurately record care plans and the outcomes in the medical records.	Accepted	The Head of Healthcare requested clinical staff who undertake care plan reviews to document any changes on the plan itself or notate SystmOne if it has been reviewed without change (July 2021).	Head of Healthcare	Complete
2	The Governor should ensure that a family liaison officer is appointed for prisoners who are seriously or terminally ill and that the next of kin is kept informed of the prisoner's condition, in line with PSI 64/2011.	Accepted	A process has been initiated with the healthcare team to ensure that information sharing occurs when a prisoner is deemed to be in a serious or terminally ill condition. A pathway has been created to ensure that prison staff are aware of the clinical position and can appoint a Family Liaison Officer where required. This includes emergency and non-emergency situations.	Governor Head of Safety	March 2022
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a	Accepted	A Notice to Staff was issued in February 2022. This restated that all authorising managers must satisfy themselves of the actual risk the prisoner poses, both of escape and to the public, prior to dispatching the escort and must also consider the physical wellness, mobility of the individual prisoner. This notice reiterated the findings of the Graham Judgement 2007.	Head of Safety	February 2022

	prisoner and are based on the actual risk the prisoner presents at the time.				