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

Mr Eral Morgan on 17/02/2021 at HMP Oakwood

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	Practice Plus Group (PPG) and NHS England and Improvement should undertake further enquiries to ensure that healthcare agencies which provide staff to prisons are appropriately trained, competent and are practising safely, and Practice Plus Group should: • undertake a clinical audit examining the effectiveness of learning following any significant incident and governance managers need to assure themselves that this learning has been embedded; and • Undertake a clinical audit of records made following an emergency response (after Mr Morgan's death) to assess the quality of record keeping.	Accepted	The Health and Justice team within NHS England and Improvement are developing an agency staffing assurance document to be sent to all providers in relation to their deployment of agency staff. The Head of Healthcare at HMP Oakwood has shared their internal investigation findings with the National Clinical Team for the Practice Plus Group. As a result of this the National Clinical Team issued an alert nationally to all PPG Health in Justice sites explaining that from the end of March 2021 all agency staff must have Resuscitation Council accredited ILS (immediate life support) training before they can work in an emergency response capacity. An agency staff checklist was also designed and disseminated for Heads of Healthcare to adopt for assurance. HMP Oakwood's healthcare team were an early adopter of the Patient Safety Incident Response Plan in 2020 and as such have robust measures in place to identify learning from serious incidents.	NHS England & Improvement Head of Healthcare Practice Plus Group	November 2022 Complete

			The plan promotes a response to patient safety incidents in a way that ensures they learn from them and improve. After a significant incident (serious incident or death in custody), a post incident review and clinical case review is undertaken as part of the internal investigation. This is a chance to reflect on the event and identify both good practice and areas of improvement. Any learning identified after the review is shared with the healthcare team and tracked via staff 1:1s with their line manager and through clinical supervision sessions to ensure it has been embedded. Training has been completed by the healthcare team regarding the correct documentation and use of the medical records system, SystmOne. It has also been reiterated to staff that all clinical attendees at an emergency response must document their own report on the patient's medical records to maintain up to date record keeping. A clinical audit covering post incident learning and record keeping will be undertaken to check the effectiveness of this.		August 2022