

## Death in Custody Action Plan for: Male prisoner

Establishment: HMP Brixton

Date of Death: 3 December 2010

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	Prisoners who have a diagnosis of any long term or chronic condition should have an appropriate care plan, including referrals for specialist care as appropriate.	Accepted	<p>All prisoners who have long term or chronic conditions have a care plan in place. As part of clinicians' assessments and delivery of care each patient needs to have their care package designed to facilitate appropriate discharge of care. A care plan is designed in direct consultation with a patient when it is required. Care plans are fully documented on SystmOne (patient record system) and should articulate the care to be discharged and the frequency by which certain interventions are carried out. Where a patient refuses or declines any intervention and where they are deemed to have full capacity to refuse or decline, patient choice is respected and clinicians cannot force patients to undertake the treatment interventions. All referrals are captured on SystmOne and hospital discharge letters accompany patients upon hospital discharge and these are in turn scanned on SystmOne against the patient's notes. There is a documentation audit which is undertaken annually where clinicians' documentation is audited, however it doesn't specifically look at care plans alone but the Lead GP randomly audits clinicians' assessments and management plans and any concerns are flagged through the incident reporting process.</p>	Immediate	

## Death in Custody Action Plan for: Male prisoner

Establishment: HMP Brixton

Date of Death: 3 December 2010

2	The Head of Healthcare should ensure an appropriate and clinically informed approach to prioritising external medical appointments in the event of insufficient escort staff for all appointments.	Partially Accepted	From a healthcare perspective there is a system in place where all escorts are prioritised by senior nurse and a GP in order of clinical risk. The administrative team also liaise directly with the referral hospital about rescheduling appointments where required and this is undertaken following clear instructions from the senior clinicians. Healthcare liaises with Oscar 1 about hospital escorts and decisions about prioritising escorts are made on the basis of available resources		
3	Following the death of a prisoner a clinical debrief should be held to allow healthcare staff involved in their care the opportunity to discuss the case and to identify any future learning.	Accepted	Usually following a DIC in the prison there is a hot de-brief held and chaired by the Prison Governor where all staff members involved with the patient/ prisoner's care are invited. In healthcare similarly the Head of Healthcare holds a clinical de-brief where clinicians retrace the patient journey and identify any quick lessons learnt pending full investigation. Additionally each morning in the Head of Healthcare's brief there is a standing complexity agenda item where complex cases are discussed. This action will be enforced irrespective of whether the patient died whilst out at hospital or in prison.	Immediate	
4	The Governor of Brixton should remind prison staff that prisoners who are suffering from a terminal illness should be formally	Accepted	A note to SMT members has gone out		

**Death in Custody Action Plan for: Male prisoner**

**Establishment: HMP Brixton**

**Date of Death: 3 December 2010**

	assessed for release on compassionate grounds. Any information relating to such an assessment should be formally documented.				
5	The National Offender Management Service and the Department of Health should issue instructions to ensure that all staff working in prisons are aware of the mandatory instructions contained in PSO 27/2010, in particular that staff should fully co-operate with a death in custody investigation.	Accepted	Prison Service Instruction 64/2011 replaces PSO 2700 Suicide Prevention and Self-harm Management, PSO 2750 Violence Reduction, and PSO 2710 Follow Up to Deaths in Custody. The PSI supports the 'Management of prisoners at risk of harm to self, to others and from others' Specification and sets out the NOMS framework for delivering safer custody procedures and practices to ensure that prisons are safe places for all those who live and work there. Included in Chapter 12 is the mandatory action <i>Staff must co-operate fully with all investigations following a death, including those by the police, the Prisons and Probation Ombudsman (PPO), the Health and Safety Executive (HSE) where applicable and the coroner's inquest.</i>		