

Action Plan – John Franks. HMP Birmingham. NC. 05/08/2017

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that the National Early Warning Scores (NEWS) system, or equivalent system for a community service, for recording clinical observations is introduced as soon as possible to support clinical decision making.	Accepted	HMP Birmingham has an algorithm for the assessment of cardiac pain (which is outlined in local training) and this algorithm is now contained within the emergency red bags. The algorithm has been updated and developed and is specific to cardiac assessment. It will be added as a template to SystemOne to ensure clinical observations can be accurately recorded and documented.	31 March 2018 Head of Healthcare
2	The Head of Healthcare should ensure that all primary care staff are fully trained in the use of a portable ECG machine and aware of symptoms that may indicate cardiac problems.	Accepted	Training is currently taking place for all primary care nurses within the prison to use portable ECG machines alongside renewed cardiac assessment training.	31 March 2018 Head of Healthcare
3	The Head of Healthcare should ensure that an audit takes place of prisoners with long-term health conditions and that long-term care monitoring is put in place in line with NICE guidance.	Accepted	A review is underway of how Long Term Care cases are identified on SystemOne to enable an accurate live register of prisoners with a Long Term Care with an annual review 'flag' or reminder. An audit will be conducted in 6 months' time to ensure this new system is embedded and effective.	31 July 2018 Head of Healthcare
4	The Director should ensure that appropriate records are kept of all actions taken following a death in custody.	Accepted	It is acknowledged that the record of ACCT reviews having been completed were missing. All Duty Directors and the Safer Team will be sent email instructions before the end of February reminding them to ensure that appropriate records are kept of all actions taken following a death in custody.	End of February 2018 Head of Safer Custody

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5	The Director should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody, in line with PSI 58/2010.	Accepted	It is accepted that errors were made when providing evidence to the PPO. Since then, systems were reviewed and staff have been briefed, to ensure that everyone involved is aware of the process. The new Head of Safer Custody and Safer Custody team will ensure that documents are provided promptly in the future. In order to provide further assurance and confidence in the process, the Head of Safer Custody has emailed all Family Liaison Officers and the Safer Custody team to remind them to provide documentation as required. There is a new checklist now in place to ensure that all information is provided as required.	End of February 2018 Head of Safer Custody