

Action Plan – Mr Thomas Mitchell at HMP Bullingdon - Natural Cause on 08/04/2019

No	Recommendation	Accepted /Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that control room staff call an ambulance as soon as an emergency code is called.	Accepted	Guidance was reissued to staff regarding emergency codes; safety week in June 2019 reinforced staff knowledge and all staff were issued with emergency code cards. Posters were issued throughout the prison and the responses to codes are monitored as part of daily operational briefing	Completed Safer Custody
2	The Governor and Head of Healthcare should ensure that during an emergency response, all staff maintain accurate and contemporaneous records of events, issues, concerns and action taken.	Accepted	Guidance issued to staff in September 2019 ensured all staff are aware of the need to keep accurate and contemporaneous records including the use of decision logs by duty managers. Governor will issue repeat reminders to managers at daily operational briefing. In addition, planned Friday Morning training session will focus in part on this to up skill staff.	Complete Governor & Healthcare
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 prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Guidance was reissued to staff in September 2019 regarding the use of restraints on hospital escorts. The escort paperwork has also been updated to ensure this is considered. This guidance contains case studies indicating what level of restraints will be applicable in certain situations. Operational Senior Management Team members have been briefed. The decision to remove restraints on escort is reviewed quickly in those cases where the prisoner leaves the prison with restraints applied so the impact on the prisoner is minimised.	Complete Heads of Healthcare & Security
4	The Head of Healthcare should ensure that all relevant healthcare staff receive training in how to complete escort risk assessments for patients going to hospital.	Accepted	Healthcare staff received additional training on completion of PER's for escorts in June 2019. Additionally, this will be discussed and monitored at the Local Quality Delivery Board (monthly meeting between Governor and Healthcare).	Complete Healthcare

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5	<p>The Prison Group Director for South Central Prisons should satisfy himself that effective Measures have been taken to address Bullingdon's continuing failure to comply with case law on the use of restraints.</p>	Accepted	<p>Effective practice will be shared with the establishment. The guidance will be shared with the SMT and the Head of Safety will provide a verbal brief to the SMT and Custodial Managers and gain a signature from those receiving guidance.</p> <p>Additional measures will include, conducting regular random checks of escorts by the Group Safety Team on behalf of the Prison Group Director to ensure appropriate consideration of the application of restraints.</p> <p>The Head of Safety, Group Safety Lead, Clinical Lead and Head of Security will review current risk assessment against effective practice.</p> <p>The Group Safety Team will also monitor progress and effectiveness through visits and raise with the Prison Group Director and Governing Governor any concerns.</p>	<p>October 2019 Head of Safety</p> <p>November 2019</p>
6	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> • a prisoner's next of kin is informed when a prisoner is admitted to hospital seriously ill; and • a family liaison officer is appointed promptly in these circumstances. 	Accepted	<p>Where a prisoner is critically ill (a terminal diagnosis or high likelihood of imminent death) the next of kin will be informed as soon as practicable. Other cases will be considered on a case by case basis and will be informed by the likely risk to the public, risk to the prisoner and risk to staff, as well as their clinical prognosis.</p> <p>A Family Liaison Officer will be appointed by the Safer Custody Department at the earlier possible opportunity. At present this capability is hindered by the lack of trained FLO's in establishment (1 at present). Arrangements were in place for four members of staff booked on the training course in September/October but one of these has been cancelled. This leaves 1 member of staff booked on the October</p>	<p>Complete Healthcare & Senior Management Team</p> <p>Complete Safer Custody</p>

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			course. We are actively attempting to book new courses as spaces come up. Until this capability is increased we have FLO's based at Grendon/Springhill as a contingency.	
7	The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.	Accepted	Copies of the draft report were circulated to relevant staff members as is usual practice.	Complete Healthcare & Safer Custody