

Action Plan – Mr Delroy Brown at HMP Swaleside – Natural Causes on 03/03/2019

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • there is a clear process, including effective communication between staff, for transferring prisoners to hospital urgently, where there is a medical need; • there is a clear escalation and clinical care review process for clinical staff to follow if there is a delay in prisoners being transferred to hospital; and • detailed notes are made in the medical record. 	Accepted	<p>Guidance has been reviewed and published in April 2019 along with giving staff detailed direction on the process that should be followed when transferring a prisoner to outside hospital.</p> <p>This includes the escalation pathways to be taken in the event of any delay sending a patient to hospital.</p> <p>All actions taken and decisions made should be recorded in the patients' medical record</p>	<p>Complete</p> <p>Governor & Head of Healthcare</p>
2	<p>The Head of Healthcare should ensure that all healthcare staff understand the legal position on the use of restraints and that it is their responsibility to provide information about the prisoner's current state of health (to enable prison managers to make decisions based on the actual risk the prisoner presents at the time).</p>	Accepted	<p>Guidelines were re-issued in April 2019 on the cuffing arrangements for escorts. Senior Management Team members were instructed how to risk assess a prisoner appropriately before being discharged to hospital so as to ensure that the actual risk(s) of the prisoner at the time are considered.</p> <p>Healthcare staff have been reminded of their responsibilities to input into the risk assessment about the prisoner's physical ability to escape.</p>	<p>Complete</p> <p>Head of Healthcare</p>

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3	<p>The Executive Director for the Long-Term and High Security Estate should personally provide the Ombudsman with an update on the progress in addressing the prison's continuing failure to comply with case law on the use of restraints.</p>	Accepted	<p>The Executive Director is satisfied that the guidance and forms in use comply with the legal judgement. In order to clinical staff understanding of the use of these forms, it has been arranged for the Group Safety Team to deliver joint training with Casework and a PPO representative at Swaleside. Healthcare and Operational Managers who are involved in the completion of risk assessments in relation to the use of restraints will be invited to improve individual performance and ensure the use of restraints is appropriate. Since the investigation, there has also been a change in the management of those who are near the end of life. Cuffing arrangements for these individuals are now agreed in advance and shared with multi-disciplinary teams, and these arrangements are available to those who may have to make quick decisions in a medical emergency.</p>	<p>September 2019</p> <p>Group Safety Lead & Safer Custody Casework, HQ</p>
4	<p>The Governor should ensure that all staff are aware of their responsibilities under PSI 64/2011, specifically:</p> <ul style="list-style-type: none"> • staff must co-operate fully with the Prisons and Probation Ombudsman following a death; and • staff must retain, and securely store in a locked cabinet with signed 	Accepted	<p>We currently have a system in place where all records available relating to a prisoner whom has died in custody are stored securely. The documentation is collated immediately after a prisoners passing and stored securely in a specific office which can only be accessed by a finite number of staff. Copies are made of all documentation so that all parties involved in the investigation and the Inquest that follows thereafter are able to have access to any information they require.</p> <p>To ensure all Staff are fully aware of their responsibility to fully co-operate with the Prisons and Probation Ombudsman's investigations following a</p>	<p>Complete</p> <p>Governor</p> <p>September 2019</p>

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	access only, all documentation (except for the clinical records) relating to the deceased prisoner for investigation by the PPO		death in custody in accordance with the above procedure a Notice to staff will be drafted and sent out to the entire staffing group in September 2019.	Governor
5	The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: the prison GP; the Custodial Manager who was duty manager on 11 January 2019; the nurse who completed the healthcare section of the escort risk assessment on 1 March 2019; and the prison manager who authorised the use of restraints on 1 March 2019.	Accepted	The findings of the investigation report will be shared with all mentioned staff in September 2019.	September 2019 Governor & Head of Healthcare