Action Plan – Mr John Smales at HMP Leeds – Natural Causes on 13/01/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS2) to assess prisoners effectively and ensure that any clinical deterioration is appropriately addressed.	Accepted	All clinical staff have NEWS2 added on eLearning as part of their mandatory training. An email reminder was sent to all clinical staff on 06/05/20 regarding the importance of using NEWS2 template. A NEWS2 escalation algorithm has been developed and circulated among all clinical staff. The NEWS2 escalation algorithm is also displayed in staff areas. Compliance with NEWS2 training is currently 100%. Additionally, the Primary Care Matron completes clinical audits on use of NEWS2 template as part of the PROTECT audit quarterly.	Complete Head of Healthcare
2	The Governor should ensure that staff record significant information about the welfare of prisoners in the wing observation book.	Accepted	A Governor's Order (G.O) will be created and issued advising staff of their responsibility to document key information about the welfare of prisoners in wing / unit observation books. Daily triangulation is completed to check all wing / unit observation books and cross references entries alongside IRS, Mercury and the daily briefing sheet. Healthcare staff have access to wing / unit observation books and they can provide key information and raise concerns by endorsing observation books. A Staff Information Notice (SIN) will be published to remind staff about their responsibility to check and read the contents of observation books.	April 2021 Governor

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No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			There is a requirement for Duty Governors to visit a minimum of 3 wings daily and sign observation books ensuring they have read the contents leading back to the previous Duty Governor check.	
3	The Governor and Head of Healthcare should remind staff to keep accurate records when they are involved in an emergency response.	Accepted	The contingency plans for Deaths In Custody will be updated to ensure the Silver Commander reminds all staff of their responsibility to create and maintain accurate records of the incident and incorporate key information into their statements, A Staff Information Notice (SIN) will be published to remind staff of their responsibilities in creating and maintaining accurate records of emergency responses. Healthcare Response An email was sent to all healthcare staff (in November 2020) reminding them that all staff who attend medical emergency must individually make entries in the medical records. Healthcare staff have also been reminded that soon after attending emergency response incidents, they should draft witness statements as part of record keeping and investigation process.	April 2021 Governor Complete Head of Healthcare
4	The Governor should ensure that staff assigned to wear Body Worn Video Cameras (BWVC), activate them at the earliest opportunity during a reportable incident.	Accepted	The Control Room are aware to remind staff to activate BWVC when an incident (Code Blue / Code Red) is declared. A Governor's Order (G.O) will be created and published to remind staff of the necessity to deploy BWVC where possible at the earliest opportunity during a reportable incident. This will be	April 2021 Governor

Action Plan – Mr John Smales at HMP Leeds – Natural Causes on 13/01/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			issued every 6 months to ensure new staff are briefed and this will feature in the weekly bulletin to ensure effective communication.	
5	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	The Head of Safety will arrange to bring all identified staff together to complete a full review of the report and allow for analysis of the Ombudsman's findings. Staff will be allowed time to reflect on the role they played and identify where improvement in communication, documentation and escalation can be made. Healthcare Response This report will be shared with all healthcare staff named within the report and given an opportunity to complete reflection piece on their involvement with care to the deceased.	April 2021 Head of Safety & Head of Healthcare