

Action Plan – Mr David Smithers at HMP Gartree – Natural Causes on 28/07/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • The FAST tool is in place as an additional template on the clinical system. • All healthcare staff are able to recognise stroke symptoms using the FAST tool. 	Accepted	<p>Following our investigation into the death of David Smithers we requested that the high risk emergency response template is updated to include the FAST tool. This request was discussed at the Nottinghamshire Healthcare Offender Health Quality Improvement meeting in October 2020. Following discussion, it was felt that the BEFAST (B-Balance/behaviour, E-eyes, F-face, A-arms, S-speech, T-time) should be added to the emergency templates for offender health. The adding of the tool for the template has been raised with the practice development Matron and was added in February 2021.</p> <p>The FAST tool was shared and discussed with staff in August 2020 following the death of Mr Smithers and has now been updated to BEFAST. It will also be included in 1:1 clinical supervision.</p>	<p>Complete</p> <p>SystemOne analyst - Notts healthcare Offender health</p> <p>Complete</p> <p>Clinical Matron for Physical health</p>
2	<p>The Governor should ensure that control room staff understand they must call an ambulance as soon as an emergency code is called.</p>	Accepted	<p>The Notice To Staff (NTS) 80/2020 Emergency Codes has been republished and re distributed to staff, so as to ensure that an ambulance is called following emergency codes and that access to both the prison and the individual prisoner is not delayed.</p> <p>Operations Custodial Managers will complete monthly assurance checks on code red and blue calls, to review the timings of calling an ambulance following emergency code raised over the net. Any follow up action will be followed up to ensure compliance with the NTS.</p> <p>Assurance will be tested through monthly safer custody meetings</p>	<p>Complete</p> <p>Head of Operations</p> <p>March 2021</p>

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3	<p>The Governor should revise the risk assessment form for hospital escorts to make it clear that:</p> <ul style="list-style-type: none"> • healthcare staff must provide information on the prisoner's current state of health and mobility; and • prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed 	Accepted	<p>Healthcare clinical matron will share the revised risk assessment form with nurses and ensure that staff provide appropriate clinical information to assist the prison in decision making. This will include information about the prisoner's health and mobility at the time.</p> <p>Healthcare staff to document information added to the risk assessment in the patients SystmOne health record</p> <p>Risk assessment form to be changed to include a section for prison managers approving escort to document and sign to state they have taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.</p> <p>Assurance of process is to be gained through a monthly review of Risk assessments and to be reviewed at the monthly safer custody meeting. This is due to start from March 2021.</p> <p>The PPO bulletin on the Graham Judgement has been shared with all operational managers in February 2021 and all operational managers will be required to confirm understanding of the new risk assessment and PPO bulletin by March 2021.</p>	<p>March 2021 Clinical Matron for Physical health</p> <p>March 2021 Head of Security</p>
4	The Deputy Director for Long Term & High Security Prison Group should write to the	Accepted	The Group Safety Lead on behalf of the Deputy Director is reviewing the measures that will be implemented to address the concerns identified by the Ombudsman's office. The Deputy Director will write to the Ombudsman in May	May 2020 Deputy Director

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	Ombudsman setting out what he is doing to satisfy himself that managers at Gartree 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.		2020 when a site visit has been completed to ensure on-going compliance and also review the documented evidence to support the accepted recommendations within the report.	Group Safety Lead for Long Term & High Security
5	The Governor should ensure that all staff understand the importance of ambulance staff having prompt access to prisoners in medical emergencies.	Accepted	The delay for ambulance access will be investigated to gain a full understanding of the reasons and any staff will be informed and actions allocated where necessary. To support this process a Governors order will be published regarding importance of ambulance staff having prompt access to prisoners in medical emergencies. Assurance of process to be checked through monthly review of ambulance entry times into the establishment and reviewed at safer custody meetings to test assurance.	March 2021 Head of Operations
6	The Head of Healthcare should contact the ambulance service for details of the ambulance crew's concerns and take any appropriate action in response,	Accepted	The Head of Healthcare will contact East Midlands Ambulance Service (EMAS) with regards to concerns expressed by the paramedics. The Head of Healthcare did respond to NHSE in regard to concerns raised, which included the information shared with ambulance control by the prison.	March 2021 Head of Healthcare

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	including disciplinary action if appropriate.		No formal report was however submitted by the ambulance service.	
7	NHS England should follow up the safeguarding report and take any appropriate action in response.	Accepted	NHS England Commissioners contacted the Head of Healthcare at HMP Gartree regarding concerns shared by the clinical reviewer. The Head of Healthcare responded to NHSE. Action taken includes the request to the Trust to update the emergency response template to include BEFAST. No safeguarding report however was submitted by EMAS.	Complete NHS England