

**Action Plan – Mr Colin Wraight at HMP Rye Hill – Natural Cause on 28/10/2020**

| <b>No</b> | <b>Recommendation</b>   | <b>Accepted/<br/>Not<br/>Accepted</b> | <b>Response</b>  | <b>Target date<br/>for<br/>completion<br/>and function<br/>responsible</b> |
|-----------|---|---------------------------------------|--|--|
| 1         | The Head of Healthcare should ensure that clinically vulnerable patients are reviewed at appropriate intervals when suffering from acute infections.  | Accepted                              | <p>The following actions were implemented in April 2021:</p> <ol style="list-style-type: none"> <li>1. Patient Acuity Tool to be reviewed daily;</li> <li>2. Patient suffering from acute infections to be included onto the standing agenda for the Multi-Disciplinary daily staff briefing/safety huddle; and</li> <li>3. Acutely unwell patients will be reviewed at least daily – patients to be added S1 ledger that will be reviewed daily by the shift leader.</li> </ol>   | <p>Complete</p> <p>Head of Healthcare</p>                                  |
| 2         | The Head of Healthcare and the Director should ensure that key staff, particularly clinical staff, are aware of all prisoners with an active Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form and understand what this means during an emergency response. | Accepted                              | <p>DNACPR processes were included in organisational and local induction processes for substantive and agency staff in March 2021.</p> <p>Prisoners with an active DNAR are recorded/highlighted on the clinical white board in the Healthcare work office (from March 2021).</p> <p>From May 2021, the Senior Healthcare Manager will inform the prison communications Department Monday to Friday of prisoners with an active DNAR. Weekend's communications department will be contacted by the shift leader (Hotel 2).</p> <p>Local process map for the management of patients with a DNACPR will be devised and shared with substantive staff and Med Team Agency (temporary worker provider).</p> | <p>Complete</p> <p>July 2021</p>   |

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|           |  |                                       | Prisoners with an active DNAR will be included onto standing agenda for Multi-Disciplinary daily staff briefing/safety huddle.  | July 2021  |
| 3         | The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, the Director should ensure there are no delays in escorting ambulances and paramedics to the patient and should ensure that staff responding to a medical emergency are aware of the most appropriate routes for escorting ambulances. | Accepted                              | <p>All routes for emergency vehicles have been reiterated to staff by way of a Notice to staff issued in April 2021 issued by the Head of Security. This included a diagram of the prison and the route ambulances would need to take.</p> <p>This will form part of the ongoing annual tool box talks which go out to staff.</p>                                 | <p>Complete</p> <p>Head of Security</p>                                    |
| 4         | The Head of Healthcare should ensure that night staff respond to emergencies immediately.  | Accepted                              | <p>The emergency response processes are to be included in organisational and local induction processes for substantive and agency staff.</p> <p>Additionally, night nurses will be advised of emergency response processes at night. The Med Team Agency will cascade emergency response processes out to all temporary workers who provide night duty cover.</p> | <p>July 2021</p> <p>Head of Healthcare</p>                                 |
| 5         | The Head of Healthcare should ensure that healthcare staff record evidence of the actions they took during an emergency and their  | Accepted                              | All staff were sent the NMC record keeping guidance in June 2021, this includes an aid memoire that outlines key information that must be included when recording entries in relation to an emergency response to be developed.   | <p>Complete</p> <p>Clinical Lead</p>                                       |

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|           | decision-making in the patient's medical records.   |                                       | Consideration will be given to developing an emergency response template on S1.   |  |
| 6         | The Head of Healthcare should ensure that all staff, including those employed via agencies, make themselves available for interview by the PPO and clinical reviewer investigating a death in custody, in line with Prison Service Instruction (PSI) 58/2010.                             | Accepted                              | G4S Health Operational Director has informed all Temporary worker providers in June 2021 of this requirement.   | Complete<br><br>Head of<br>Healthcare                                      |
| 7         | The Head of Healthcare should share this report with the nurse on duty when Mr Wraight died and with the agency that employs her to ensure they are aware of the Ombudsman's findings.  | Accepted                              | The report and findings were shared with Med Team Agency employers of the nurse in April 2021.  | Complete<br><br>Head of<br>Healthcare                                      |
| 8         | <p>The Director and Head of Healthcare should ensure that after all deaths in custody:</p> <ul style="list-style-type: none"> <li>• a hot debrief is held immediately, in line with PSI 02/2018;</li> <li>• a senior member of staff acts as the debriefer and a member of the</li> </ul> |                                       | <p>The support required by Healthcare staff, is to be considered by the Healthcare Senior Manager at the time of the incident; the local death in custody process will include this.</p> <p>A Healthcare notice was sent to staff in April 2021 advising of the need to attend and participate in a "hot debrief" in line with the PSI.</p> <p>There are minimal staff available to attend a hot debrief if a death occurs overnight, therefore the session will be held at the end of the shift or on an</p> | <p>Complete</p> <p>Head of<br/>Healthcare</p> <p>Complete</p>              |

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|           | <p>care team attends;</p> <ul style="list-style-type: none"> <li>• all staff directly involved in the incident, including healthcare staff, are invited; and</li> <li>• consideration is given to whether any staff not directly involved in the emergency response, but who provided care, may need support and debriefing.</li> </ul> |                                       | <p>individual basis. Full contingency plans are in place in the command suite in connection with this and Head of Safer Custody will deliver death messages rather than the Duty Director to ensure that these plans are adhered to. A desk top exercise has taken place (on May 2021) for this to be reviewed in full.</p> | <p>Head of Safer Custody</p>   |
| 9         | <p>The Director should ensure that the cell bell recording system is regularly checked and audited to make sure that the data is accurate.</p>  | Accepted                              | <p>The call bell system is checked daily Monday to Friday and is also in the process of being upgraded (May 2021) to be able to identify individual officers answering call bells. Any faults are reported to the Duty Director and Facilities Management.</p>  | <p>Complete<br/><br/>Head of Residential</p>                               |