Action Plan- Graham Butterworth . HMP Lincoln . NC . 05/12/2017				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Head of Healthcare should ensure that healthcare staff: • receive training to help detect and treat early warning signs of deterioration in prisoners; • take and record observations as required; and • record actions and decisions about prisoners' ongoing care in their medical records	Accepted	All staff are being trained in the updated National Early Warning Score 2. This training commenced in January 2018 and is ongoing. The Head of Healthcare introduced a patient report form, in March 2018, to capture all relevant patient observations. To assist staff completing the form there is also an Aide memoir on the back of the form. Once the form is completed it is scanned onto the patient record. Staff were trained and briefed of the changes in April 2018 at Senior Management Team and daily meetings. All healthcare staff have been instructed to ensure clinical decision making is justified through clinical observations and all actions and decisions are now being recorded on the patient report form and on SystmOne. Staff have also been instructed to ensure prisoners are reviewed when concerns are raised and this is documented with a full set of baseline observations. A response template was introduced in March 2018 to capture data that can be audited for compliance.	Completed Head of Healthcare
2	The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on	Accepted	As there have been several recommendations for HMP Lincoln around the issue of the use of restraints additional measures have been put into place to ensure that those involved understand that the risk assessments clearly record the justification of restraints and	Completed Head of Residence and Safety

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	prisoners taken to hospital, understand the legal position; 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		that the actual risk(s) include the prisoner's health. A Notice to Staff that sets out the considerations relating to seriously and terminally ill prisoners and escort risk assessments has been issued to all staff continuously in the last 12 months. The considerations and guidance in the Notice were discussed with the Senior Management Team (SMT) in a team meeting in January 2018. Instructions on the justification of the use of restraints and information about the health of the prisoner were reiterated at this meeting. Additionally, the Deputy Governor implemented a system whereby the Notice is discussed with SMT members at one to one supervision sessions. This means that individuals' understanding of the considerations is discussed to ensure compliance with the Notice.	
3	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible.	Accepted	As soon as notified of prognosis we will take all steps to contact the next of kin. A Notice to staff will be issued to remind all escorting staff of the need to update the establishment when a prognosis is made or where a prisoner is admitted to a High dependency Unit in order that the next of kin may be informed.	May 2018 Head of Residence and Safety
4	The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death, in line with national guidance.	Accepted	On 27/04/18 the Governor emailed a document, entitled Death in Custody Grab pack, to all Governor grades and Custodial Managers which provides guidance on actions to be taken when a Death in Custody occurs. This document reminds the Duty Governor of the need to Contact the next of kin and to record the time of the contact.	Completed Governor

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			Where contact cannot be achieved by the establishment in a reasonable timeframe the nearest HMP establishment to the next of kin will be contacted and asked to Inform the next of kin on our behalf.	
5	The Governor should ensure that a debrief is held promptly after the death of a prisoner and that the staff involved are offered effective support.	Accepted	A review of the Death in Custody action Plan had been undertaken. On 27/04/18 the Governor emailed a document, entitled Death in Custody Grab pack, to all Governor grades and Custodial Managers which provides guidance on actions to be taken when a Death in Custody occurs. Conducting a Hot Debrief for staff is one of the actions stated in the document.	Completed. Head of Operations