

Action Plan – Mr Gareth Slater at HMP Dovegate – Natural Cause on 20/09/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that nurses are aware of the significance of the symptom of facial weakness and that robust arrangements are made for patients complaining of facial weakness to be assessed by a doctor or suitably trained nurse.	Accepted	All nurses have been made aware that in the event of reports of facial weakness, even where there is no visual evidence, the patient must be referred for assessment by a suitably trained advanced nurse practitioner, or doctor at the earliest opportunity. Where there is physical evidence of a facial weakness present, then the patient must be sent to hospital for assessment.	Complete Head of Healthcare
2	The Director should ensure that all operational staff have access to a working radio at night.	Accepted	<p>Since this event there have been a number of upgrades to our system implemented in March 2021 including:</p> <ul style="list-style-type: none"> • New radio base station with increased area coverage • 100 batteries purchased and put into the system • Increased frequency and improved focus on Net Test Calls • 400 ear pieces issued to staff <p>We will continue to monitor the radio provision going forward.</p>	Complete Assistant Director (AD) of Security
3	The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies including that staff:	Accepted	Full training is given on an initial training course regarding correct radio procedures and correct code calling. The training also includes practical training on the use of the radios where delegates are assessed. This includes clear communication about the correct reporting of nature/location. Tool box talks have been issued on the subject of code calling and the subject is included in staff briefings.	Complete Training Manager & AD Safety

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	<ul style="list-style-type: none"> • use a medical emergency code immediately, by radio where possible, where there are serious concerns about the health of a prisoner; and • efficiently communicate the nature and location of a medical emergency so that there is no delay in healthcare staff attending. 			
4	The Director should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman’s findings with him.	Accepted	AD for Safety has shared report with Officer A. The findings raised in the report have been discussed (May 2021).	Complete AD Safety
5	The Head of Healthcare should ensure that staff: <ul style="list-style-type: none"> • understand their professional requirement, in line with the Nursing and Midwifery Council’s guidance on record keeping, to make accurate, 	Accepted	The NMC guidance on record keeping has been shared with all healthcare staff, via email and at daily team meetings, and all staff have been reminded of the importance of recording the reasons for missed appointments.	Complete Head of Healthcare

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	timely and contemporaneous notes in prisoners' medical records; and • record the reasons for missed appointments.			
6	The Director should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO, in line with PSI 58/2010.	Accepted	At the time of this incident there had been several personnel changes within the administration team. Just prior November 2020, there is a comprehensive induction and training plan in place to ensure that all evidence pertaining to a death is retained and provided to the Ombudsman.	Complete AD safety & Governance Manager