Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Head of Healthcare should ensure that all patients with HIV are referred to the appropriate external sexual health service and sexual health link nurse from the local hospital and their medication is obtained to provide continuity in treatment.	Accepted	The Healthcare department has implemented an agreement with Ipswich Hospital which ensures that all referrals are made within a short timeframe so that the correct treatment can be given. As part of the agreement a specialist nurse from Ipswich Hospital conducts a visit to the prison and advises on treatment as well as providing any further information on patient's healthcare in the community. The nurse will also continue the care pathway following release through the Coelho clinic based at Broomfield Hospital.	Head of Healthcare Completed
2	NHS England's Regional Director for the East of England should refer Nurse A to the nursing and Midwifery Council with a view to an investigation to determine why Mr Shiri did not receive his anti-retroviral medication for five months.	Accepted	Referring a clinician to their professional body is the responsibility of the employing organisation following investigation. Nurse A worked at HMP/ YOI Chelmsford when healthcare was provided by Essex Partnership University Trust (EPUT). Castle Rock Group (CRG) is now the new provider since 1st April 2019. This recommendation has been forwarded to EPUT in order that they can take the appropriate action.	
3	The Head of Healthcare should ensure that patients with immuno-supressing illnesses have access to any specialised care required in accordance with NICE guidelines.	Accepted	Immuno-supressing illnesses are detected in reception through the routine blood-borne virus (BBV) tests that are required to take place with all new receptions. In addition to this it has been agreed with the local clinic that they will contact the healthcare department in the event of a patient receiving a custodial sentence.	Head of Healthcare Completed

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			All patients are added onto a caseload with regularly updated personal care plans which are reviewed accordingly. The BBV and HIV teams will visit all patients jointly if the patient is complex and extra guidance is required. Results clinics are in place every afternoon for any updates regarding recent bloods taken.	
4	The Head of Healthcare should ensure that all patients with long-term conditions are seen in the long-term conditions clinic and a plan of care is documented in their medical records.	Accepted	All patients that attend the long term clinics (LTC) have a personalised care plan which is monitored and updated accordingly. This care pathway is generated at the point of reception and is then monitored by the designated Nurse Practitioner. In addition to this the RGN reviews the reception screening documents in order to quality assure the process and ensure effective screening takes place.	Head of Healthcare Completed
5	The Head of Healthcare should ensure that all physical observations are undertaken in full and NEWS 2 scoring guidance is used to inform ongoing care, interventions, monitoring and escalation pathways.	Accepted	NEWS 2 in place and is one of the templates on SystmOne. A laminated version is now provided in the response nurses grab bag for use as a practical measure.	Head of Healthcare Completed
6	The Head of Healthcare should ensure that there is a systematic process in place for reviewing blood test results, and that they	Accepted	The overall process for reviewing blood test results has been updated. Under the new process, the nurse practitioner reviews all of the blood results twice daily. The new ledger was added on SystmOne for GPs to	Head of Healthcare

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
	are done in a timely manner and clearly documented within the medical records with a plan of care.		document each patient's bloods that they have reviewed for clinical staff to access. All of the results are documented on SystmOne and the ledger identifies whose results have been checked, this is overseen by the nurse practitioner to ensure they are addressed in a timely manner. Other healthcare staff have access to the results and have received training on the new process.	
7	The Governor and Head of Healthcare should ensure that custodial staff and healthcare staff record when custodial staff refer prisoners to healthcare.	Accepted	Guidance was issued to prison staff in March 2020 which outlined key information regarding the requirement to record when prisoner referrals are made to healthcare. The guidance included information cards which detail key signs and symptoms which indicate medical warnings. It was agreed between the prison and healthcare in February 2020 that prison staff will telephone healthcare on a designated number for an immediate response in order for healthcare to provide prison staff with advice on any medical concerns prior to any referral.	Completed. Head of Safer Custody Completed Head of Operations
8	The Head of Healthcare should ensure that medical practitioners in the community can contact the healthcare department at Chelmsford by telephone to communicate emergency	Accepted	A Healthcare department number is available for external agencies to call, which is manned throughout the day by administration staff who will pass on any medical information. In addition healthcare staff visit the hospital if a patient is admitted for a length of time. A password system is also used when making enquiries in order to ensure GDPR compliance.	Head of Healthcare Completed

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
	concerns about a prisoner's health.			
9	NHS England's Regional Director for the East of England should write to the Ombudsman setting out what she has done to satisfy herself that effective action has been taken to address the serious healthcare failings identified in this report.	Accepted	A letter dated 3 February 2020 was sent to the Ombudsman from the NHS England Regional Director for the East of England.	
10	The Governor should ensure that all staff are aware of PSI 03/2013 and radio a medical emergency code appropriately.	Accepted	Staff were given full training on PSI 03/2013 and the medical code policy in January 2020. The key points from the policy are regularly circulated to all staff on the daily briefing sheet. Posters are also displayed in all wing offices detailing each code and the actions to be taken and also explaining that a dynamic risk assessment must be made when dealing with a medical emergency. All staff have received full radio training which provided specific guidance on the correct radio language to use in the communication between the incident and the control room staff. It also highlighted that all information must be consistently relayed clearly and correctly so that an ambulance is requested at the earliest opportunity. The topic of medical emergencies and the use of the correct emergency codes will be covered in Safety Day training that is currently being	Completed Head of Safety Completed Head of Operations Regional Safety Team 2021

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			organised. This was due to take place in summer 2020 but is currently on hold due to Covid-19.	
11	The Governor should ensure that staff respond promptly to messages left on the safer custody helpline.	Accepted	The Safer Custody hotline is checked a minimum of twice a day Monday to Friday, and by the Night Orderly Officer during night state. Custodial managers are reminded regularly of this duty through email communication which includes details of how to access the hotline and what to do if there are concerns that need to be actioned. Assurance that this check has been completed is done through signing the communications night log book. At the weekends during the day, the hotline is checked by the detailed ACCT assessors. Every Friday all ACCT assessors are sent an email reminding them that if they are the duty ACCT assessor over the weekend what their responsibilities are with regards to listening to the hotline and action any concerns. This email also includes details of how to make phone calls back to the family member/friend. It also states the importance of continuing to try to make contact and if they are unsuccessful then they are to email the Safer Custody mail box and one of the administration team will attempt to make contact again on the Monday. If the ACCT assessor is redeployed for any reason then they must inform the Duty Manager that the checks were not completed so that the custodial manager may then do the checks or task someone else.	Completed Head Of Safety

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			Assurance that this check has been completed is done through signing the Duty Managers book located in the gate.	
12	The Governor should ensure that bed watch staff record all important events in the bed watch log, and immediately report significant changes in a prisoner's condition to the Duty Governor.	Accepted	The process for escorting staff leaving the establishment has been reviewed and all escorting staff are now routinely briefed before leaving the establishment by a Duty Manager. Staff are reminded of the need to record all important events in the bed watch log and update the Duty Governor of any significant changes in the prisoner's condition immediately using the escort phone provided to them. This takes place every time escorting staff leave the establishment with a prisoner. Escorting staff are reminded of these requirements every day during the custodial manager daily bed watch check and they sign on their checklist to confirm they have completed the briefing. Following all escorts, all the bed watch paperwork is quality assured to ensure that all incidents and actions have been appropriately recorded. Management checks are also done daily to ensure that this happens and Governor checks are done if the bed watch is out for 72 hours or longer to ensure continuity in these events.	Completed Head of Security Completed Custodial Managers Completed Duty Governor
13	The Governor should ensure that when a prisoner is in hospital in a critical condition, their next of kin is informed and authorised to visit, without delay.	Accepted	Following the review of the escort procedures, staff have been reminded that next of kin should be informed without delay by the duty manager as soon as they are advised that the prisoner is in a critical condition.	Completed Head of Security

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
			The bed watch log provides further details to the staff on duty that they must inform the Duty Manager and Governor of any changes to the prisoner's condition and update communications every four hours and at staff hand-over. The custodial manager bed watch daily checklist was updated in June 2020 to include a check to be signed stating that consideration has been given to the condition of the prisoner and whether the stay is likely to be lengthy, meaning visits from the next of kin will need to be organised..	Completed Head of Security Head of Security June 2020
14	The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, and that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.	Accepted	Risk assessments are conducted for all prisoners being sent to hospital on a bed watch, and cuffing arrangements are determined based on how the prisoner presents and advice from the responding paramedics at the time of the escort dispatch. The current risk assessment being used was modified in June 2020 to include a point addressing that the member of staff conducting the assessment has taken into account the health of the prisoner, who provided this health related information to them and justifying the use of restraints. A notice to all staff will be sent in June 2020 to inform staff of all changes to current forms and assessments with regards to the overall escort procedure, including all bed watches and restraints.	Completed Head of Operations Head of Operations June 2020 Head of Operations June 2020

Action Plan – Mr Thokozani Shiri at HMP Chelmsford – Natural Causes on 14/04/2019				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
15	The Governor should ensure that a copy of this report is shared with staff named in this report.	Accepted	This report has been shared with all staff named within the report.	Governor Head of Healthcare Completed
16	The Prison Group Director for Hertfordshire, Essex and Norfolk should write to the Ombudsman setting out what he is doing to satisfy himself that effective action has been taken to address the serious failings identified in this report.	Accepted	A full review of all PPO recommendations linked to deaths in custody at Chelmsford was completed in February 2020 by the Prison Group Director to ensure that delivery of the actions is fully implemented within local practice. The Prison Group Director recognised that this action plan raises areas of concern not covered in the review along with areas linked to previous recommendations still requiring further work to embed some required delivery mechanisms.	Prison Group Director Completed