

## Action Plan in response to the PPO Report into the death of Mr Lewis Brown on 27 May 2024 at HMP Birmingham

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor and Head of Healthcare should review the training for reception and induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.	Accepted	<p>HMP Birmingham has reviewed and amended the training provided to reception and induction staff. Guidance detailing how to identify risk of self-harm and suicide, particularly in reception, has been distributed to all custodial managers and has been relayed to all reception and induction staff. All reception staff have now received demonstrations from the reception custodial managers on how to check and record information on the digital PER. These demonstrations are also delivered to all custodial managers during morning briefings.</p> <p>Birmingham and Solihull Mental Health Foundation Trust has put in place more robust training. Reception screening requires a high level of competence to undertake the role safely and effectively. The skills required relate both to clinical assessment but also to other factors</p>	Head of Healthcare, Birmingham and Solihull Mental Health Foundation Trust	Ongoing

			<p>including operational and security aspects of the prison setting. SOP Reception PM updated.</p> <p>Healthcare staff have classroom training and competency document must be completed before they can carry out reception screenings. They will then have shadow and supervised shifts in reception to ensure they can carry out the assessment thoroughly and identify the relevant risks.</p>	Head of Safety, HMPPS	Ongoing
2	The Head of Healthcare should review the quality and compliance with policy of reception and secondary health screens in the previous 12 months, ensure that prisoners are referred to the mental health team when appropriate, and identify any improvements required.	Accepted	<p>Dip-testing was completed and those that had not referred correctly were taken off screening. Retraining and competency skills were re-assessed until fully competent and able to carry out screenings correctly.</p>	Head of Healthcare, Birmingham and Solihull Mental Health Foundation Trust	Complete and Ongoing
3	The Governor should ensure that staff understand local policy around covered observation panels, that prisoners are appropriately challenged and blockages removed, and that there is not a culture in which prisoners routinely cover observation panels.	Accepted	<p>Custodial Managers have been reminded of the actions to be taken when an observation panel is blocked. The Night Orderly Officer will also remind all night staff at the beginning of each shift of the actions required upon the discovery of a blocked observation panel.</p> <p>Additionally, the guidance packs available on each wing for night shifts have been updated to include specific instructions in relation to completing roll checks and escalating blocked observation panels.</p>	Head of Security, HMPPS	Complete and Ongoing