	Action Plan – Mr Peter Tauroza at HMP Wandsworth – SID on 06/03/2020				
No	Recommendation	Accepted/ Not Accepted	Response		Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that reception staff thoroughly check the person escort record for all relevant risk information about newly arrived prisoners and, where appropriate, clarify risk information with escort staff.	Accepted	Training and guidance will be given to reception staff and signage will be displayed as a reminder to ensure that all Supervising Officers are aware to challenge escort contractors if paperwork is missing especially when relevant to risk. Signatures will now be received by both parties to confirm that necessary actions have been taken.		Head of Operations and Head of Reception December 2020
2	The Governor and Head of Healthcare should ensure that: •Reception and healthcare staff assess and identify prisoners at increased risk of suicide and self-harm, including those who have returned from court; and •Reception staff are appropriately trained.	Accepted	A training package is being created to deliver to all Supervising Officers (SO) who work irregularly in reception and who may be less familiar with reception processes. The training will cover the importance of identifying risks and triggers for suicide and self-harm, particularly if there has been a change in circumstances for prisoners returning from court. Training will also cover the need to flag any prisoners returning form court or videolink appearances so that they can be seen by healthcare. Consideration is being given to re-profiling the roles of staff who provide cover in reception but are not based there permanently. This would include using a smaller number of staff to increase continuity and improve awareness of reception processes. A review of reception processes will be completed by the end of the year to improve how prisoners move through the reception and first night centre. Currently, there are different flows through the building for new arrivals and for those returning from court. The review will consider how the flow through the		Head of Business Assurance ad Head of Reception January 2021

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			building for those returning form court can be improved so that healthcare are aware of returning prisoners who need to be assessed before returning to the wings.	
3	The Governor should ensure that key workers understand the need to alert wing staff if a prisoner may be at increased risk of suicide or self-harm.	Accepted	As staff do not know in advance which prisoners will be attending court the next day any issues and concerns raised by prisoners relating to court appearances and sentencing must now be added to the IR system so that this risk information can be captured in the prisoner's escort record (PER) which will accompany them to court. The Head of Safer Custody and Head of Security will provide awareness training of this new process to security staff to ensure that staff understand what information needs to be added to the PER. A Notice to Staff (NTS) will be published in October 2020setting out the new instruction to record risk information relating to court appearances and sentencing on the IR system and also to remind staff of the importance of documenting all risk related information on NOMIS case notes and in the wing observation book.	Head of Safer Custody and Head of Security December 2020
4	The Governor should ensure that any decision to move a prisoner while they are attending court is authorised by a wing manager, with the reasons for any move recorded in the prisoner's records.	Accepted	A new team was created in June 2020 who are responsible for the management of all internal moves. Training is being provided to staff working in the move team to ensure that no moves take place without a prisoner first being informed and the reasons documented; and that this does not happen when prisoners are out of the establishment. Currently, due to Covid-19 all prisoners returning from court are relocated to a different cell for safety reasons. However, the reasons for this were	Head of Decency November 2020

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			communicated clearly to prisoners through the internal prison radio station in July 2020. The internal radio station is used to communicate information to prisoners regularly.	
5	The Head of Healthcare and the lead for CGL should ensure that CGL's records are also recorded on SystmOne so that healthcare staff can access them.	Accepted	In September 2020 a training session was held with CGL staff to raise awareness and check understanding of what information needs to be added to SystmOne. This was followed up with an email to staff reiterating the expectation that relevant case notes and records must also be added to SystmOne in addition to the CGL database. Monthly supervision sessions between staff and managers provide an opportunity to identify if records have not been added to SystmOne and actions are set for staff to rectify this before the next session. The Head of Healthcare will continue to review case records to ensure that both databases match so that healthcare staff have access to all relevant information.	Head of Healthcare Completed
6	The Head of Healthcare, the Forensic Offender Mental Health Service and Business Development Manager should implement a zoning system so that mental health staff can easily identify which prisoners are under their care and create appropriate treatment plans to meet their needs.	Accepted	There is a zoning system in place which uses traffic light colour coding to highlight the clinical needs of each prisoner being managed under the mental health team. In April 2020 an email was sent to staff to remind them that the zoning system indicates how often each prisoner should be seen to ensure that their clinical needs are being reviewed and that the frequency of appointments suits their needs as per zoning.	Head of Healthcare November 2020

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			A monthly audit is now carried out on all care plans and risk assessments by team leaders. Any issues identified are discussed at monthly one to one supervision sessions with staff. Assurance of the audit is overseen by the Service Manager for Mental Health and is incorporated within clinical governance procedures.	
7	The Head of Healthcare and the lead pharmacist should ensure that there is an effective system in place so that prisoners who return to prison late receive their medication.	Accepted	The night nurse runs an audit of all missed medication for the day and takes this medication to prisoners. Any prisoner who does not attend to collect medication due to being out at court is captured through the audit and is added to the list to ensure that their medication is also received. The policy Access and Engagement HMP Wandsworth V1.2 outlines actions to be taken when prisoners do not attend to collect medication on two or more occasions. A nurse or a member of the pharmacy team will visit the prisoner to establish the reasons for non-attendance and the mental health team are also notified and will arrange to visit the individual. Following the in-cell visit appropriate follow up actions are put in place such as a review of medication. If prisoners are concerned that they have missed their medication they are able to use the emergency cell bell to convey this to staff who will arrange for the nurse to attend.	Head of Healthcare Completed