

## Action Plan in response to the PPO Report into the death of Mr Ryan Nash on 30/04/2020 at HMP Bedford

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should ensure that all managers understand the definition of Special Accommodation and the required protective measures set out in PSO 1700.	Accepted	A notice to all managers was published in May 2021 which outlined the definition and the required protective measures of using special accommodation. The notice also outlined the process for placement, holding and removing a prisoner from special accommodation and informed all managers of the requirement to read PSO 1700 and to continue to refer to it for future guidance.	Governor HMPPS	Completed
2	The Prison Group Director for Bedford, Cambridgeshire and Norfolk should ensure that prisons fully cooperate with PPO requests for information and understand that the PPO must have unfettered access to any information relevant to their investigations, in line with PSI 58/2010.	Accepted	<p>The Prison Group Director (PGD) informed all of the Governing Governors in the Bedfordshire, Cambridgeshire and Norfolk (BCN) Region in July 2021, during a Senior Leaders team meeting, to fully co-operate with PPO requests and give them unfettered access to any information relevant to their investigations. This was also reiterated through email communication following the meeting.</p> <p>The Head of Safety will also ensure that the PPO has access to all information relevant to their investigations and where any concerns arise with obtaining information, this will be immediately communicated to the Governing Governor.</p>	<p>Prison Group Director HMPPS</p> <p>Head of Safety HMPPS</p>	<p>Completed</p> <p>Completed</p>

<p>3</p>	<p>The Governor should ensure that prison staff manage prisoners identified as at risk of suicide or self-harm in line with PSI 64/2011, including that:</p> <ul style="list-style-type: none"> <li>• the ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures;</li> <li>• first ACCT case reviews are multidisciplinary and always include a member of healthcare staff and staff who have had previous contact with the individual, such as key workers or the ACCT assessor;</li> <li>• staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;</li> <li>• a case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible;</li> <li>• a multi-disciplinary review is held when there is evidence of a significant change in risk; and</li> <li>• case managers should ensure that caremaps are completed at the first ACCT case review, set specific and meaningful caremap actions, tailored to the</li> </ul>	<p>Accepted</p>	<p>The implementation of ACCT Version 6 (v6) is currently underway and the updated SASH training commenced in July 2021. ACCT v6 introduces some changes to the process by which prisoners at risk of suicide and self-harm are managed.</p> <p>Suicide and Self-Harm (SASH) training is delivered to all staff and provides guidance on the ACCT process and requirements. Fortnightly SASH training sessions are accessible to both prison and healthcare staff.</p> <p>SASH training outlines the importance of the assessment interview and the need for the ACCT assessment to be held within 24 hours after an ACCT is opened, and the first case review within 25 hours. Staff are also reminded of this requirement during daily staff briefings and it was also added to the daily briefing sheet in June 2021 as a daily visual reminder. Both the Safety Team and Orderly Officers are informed when an ACCT is opened and they are responsible for ensuring the assessment and first review are completed within time.</p> <p>Staff have been reminded in SASH training and staff briefings that all ACCT case reviews must be multi-disciplinary, and that the Case Coordinator (which replaces the case manager) must ensure that healthcare staff are always invited to attend, or provide a written contribution to, the first case review and any subsequent case reviews where they are relevant to the support offered to the prisoner, along with any other member of staff who is involved in the support offered to the prisoner. The Mental Health Team also now have a designated member of staff to attend ACCT reviews.</p> <p>A Governor's Order was published in May 2021 which provided guidance for staff that are involved in ACCT case</p>	<p>Head of Safety and Safety Team HMPPS</p> <p>Head of Safety and Safety Team Leaders HMPPS</p> <p>Head of Safety and Safety Team Leaders HMPPS</p> <p>Governor HMPPS</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>
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4	<p>The Governor should initiate an investigation into the allegations made by prisoners about the behaviour of prison officers who were on the wing on the evening and night of 29 April 2020 with a view to considering whether disciplinary action is appropriate.</p>	Accepted	<p>The Governor commissioned a formal investigation in June 2021 into the allegations made about the actions of staff which was completed in August 2021.</p>	Governor HMPPS	Completed
5	<p>The Governor should ensure that staff understand the importance of conducting roll checks as required.</p>	Accepted	<p>A Governor's Order was published in May 2021 which provided instructions to staff on the correct procedures for roll checks and outlined the importance of following these procedures at all times.</p> <p>The induction for all new operational staff was updated in August 2021 to include detailed guidance to staff on the requirements of conducting roll checks.</p>	<p>Governor HMPPS</p> <p>Head of Operations HMPPS</p>	<p>Completed</p> <p>Completed</p>
6	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> <li>• Bedford Staff Community Notice 19/2020 is updated to provide guidance to staff about measures to take when carrying out roll checks and other welfare checks on prisoners with damaged, broken or blocked observation panels; and</li> <li>• broken observation panels are replaced as soon as possible.</li> </ul>	Accepted	<p>A Governor's Order was published in May 2021 which provided instructions to staff about the measures to be taken when carrying out roll checks and other welfare checks on prisoners with blocked or broken observation panels. It included the instruction that staff must report any damaged observation panels at the time that they are discovered.</p> <p>Bedford Staff Community Notice 19/2020 was updated and reissued in October 2021. This included instructions to staff on how to check on prisoners safely using a plastic screen to look into the cell when this is necessary.</p> <p>Staff complete daily checks of all observation panels when completing roll checks and staff continue to be reminded during daily briefings to log and report any that are damaged</p>	<p>Governor HMPPS</p> <p>Head of Safety HMPPS</p> <p>Head of Safety HMPPS</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>

			or broken at the earliest opportunity. Any broken observation panels are noted in the morning meeting and then followed up the next day, to ensure that these are repaired.		
7	The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.	Accepted	<p>A Staff Community Notice was published in May 2021 which provided guidance on making the decision of when to attempt resuscitation, when not to and how to record these decisions and actions appropriately. It also outlined the circumstances in which resuscitation is inappropriate as outlined in the European Resuscitation Council Guidelines.</p> <p>Guidance on the requirements of resuscitation from the British Medical Association (BMA), the Resuscitation Council (UK), the Royal College of Nursing (RCN) and Northamptonshire Healthcare Foundation Trust (NHFT) was shared with all healthcare staff in February 2021. Staff were required to sign to show that they have read and understood the guidance. This was also discussed at the healthcare full staff meeting in February 2021.</p>	Governor HMPPS	Completed
				Head of Healthcare Northamptonshire Healthcare Foundation Trust (NHFT)	Completed
8	The Head of Healthcare should ensure that all prisoners referred urgently to the mental health team are assessed within five days, in line with the team's policy.	Accepted	The Head of Healthcare monitors the compliance of urgent mental health referrals and provides a monthly report to the Northamptonshire Healthcare Foundation Trust (NHFT) who ensure that the referrals are made within the required timeframe. This is also reported bimonthly to the Commissioner and the Governor. Any urgent referrals are now also seen by the mental health team within 24 hours.	Head of Healthcare NHFT	Completed
9	The Governor and Head of Healthcare should ensure that there is a communication plan in place between OMU and the mental health team so	Accepted	The Head of the Offender Management Unit Delivery (SPO) and the relevant Prison Offender Manager (POM) introduced a collaboration discussion in June 2021. This was to ensure that prisoners that would benefit from a transfer to a prison with a Psychologically Informed Planned Environment (PIPE)	Head of Offender Management Unit HMPPS	Completed

	that referrals to the PIPE programme are progressed and prisoners are updated about the status of their referral.		<p>course are identified, the appropriate referrals are made and the prisoner is kept updated on progress.</p> <p>The Head of the OMU appointed a single point of contact (SPOC) in June 2021 who communicates fortnightly with the Mental Health (MH) SPOC to ensure both teams are fully sighted on progress. The MH SPOC tracks the referral progress through a spreadsheet which is available to all Healthcare staff in order to monitor the process.</p>	Head of Offender Management Unit HMPPS	Completed
10	The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.	Accepted	<p>The report was shared with all named staff and the Deputy Governor and Head of Safety discussed the Ombudsman's findings with them during August 2021.</p> <p>The report was also shared with healthcare staff and the findings were discussed at a staff meeting in August 2021.</p>	<p>Deputy Governor and Head of Safety HMPPS</p> <p>Head of Healthcare NHFT</p>	<p>Completed</p> <p>Completed</p>