Action Plan in response to the PPO Report into the death of

Mr Andrew Neal on 18 August 2024 at HMP Wayland

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider all relevant information about risk.	Accepted	The regional safety team will deliver additional staff upskilling sessions to raise awareness of staff responsibilities to identify prisoners at risk of suicide and self-harm, including identifying risk and recording information, ACCT management and assurance. Additionally, an awareness presentation will be delivered during the full staff meeting. Quality assurance and random testing of staff awareness and confidence to raise and record risk will be completed in line with local strategy set assurance levels.	Head of Safety, HMPPS	August 2025
2	The Governor and Head of Healthcare should ensure that when prisoners subject to ACCT monitoring have concerns with their physical health, they are referred to the primary care team to assess	Accepted	Healthcare staff attend all planned ACCT reviews and ad-hoc reviews wherever possible. Where concerns around physical health are raised, the concern is noted on the ACCT care plan and the member of healthcare staff completes the primary care referral. When healthcare staff	Head of Safety, HMPPS Head of Healthcare, Practice Plus Group	June 2025

	and review the prisoner's health and care plan in line with NICE Guideline NG57 'Physical Health of People in Prison'.		cannot be present at the review, the case manager ensures that a referral is forwarded to healthcare. Healthcare also has a biweekly complex case clinic which involves follow up of referrals, safer prescribing and discussion of patients with dual diagnosis. ACCT upskilling sessions have been, and will continue to be, held with case managers to highlight the importance of meaningful care plans that deal with the issues and concerns that prisoners subject to ACCT are facing. This practice includes ensuring that previous actions (such as primary care referrals) have been completed and progressed when necessary.		
3	The Head of Healthcare should ensure that the mental health team has a standardised process for communicating actions agreed during consultations with healthcare staff and update the standard operating procedure to reflect this.	Accepted	The process already in place is the Psychiatrist handover ledger. Any acute concerns are raised at handover for wider team awareness and any presenting complex cases are discussed at the clinical team meeting.	Head of Healthcare, Practice Plus Group	June 2025
4	The Head of Healthcare should ensure that when prisoners do not attend for their medication on a number of occasions, a plan is documented within their medical records to ensure a multidisciplinary	Accepted	Although in this circumstance, the patient was missing morning doses but being seen in the evening. Our standard procedure is that if we identify a pattern where a patient is attending one administration time and not the other, that a conversation is held with the patient to seek to understand why this is occurring, and what	Head of Healthcare, Practice Plus Group	June 2025

	approach is taken when reviewing their care.		onward referrals are needed for medication review. This is to be a documented conversation to explore the patient's impression on the need or efficacy of their medication. The missing of medication administration was discussed in an ACCT review and documented on SystmOne following 3 days of missed morning administration. Going forward, all staff have been informed and reminded of the LOP that is in place regarding patient following up after omitted doses.		
5	The Head of Healthcare should incorporate closer healthcare observations for prisoners who are not compliant with their antidepressant medication, to monitor withdrawal symptoms and any adverse effects.	Accepted	Although in this circumstance, the patient's medications were not stopped, despite an incident of diversion, from prescriptions patient transferred to our establishment on, all patients who present with withdrawal are seen by a competent healthcare staff member and we follow the 'COWS' (Clinical Opiate Withdrawal Scale) to identify any acute symptoms that requires monitoring, treatment or escalation. Training gaps is on our agenda for upcoming quality assurance meeting, and this will include both withdrawal and monitoring of depression.	Head of Healthcare, Practice Plus Group	June 2025