

Action Plan in response to the PPO Report into the death of Mr William Roalfe on 20/11/2021 at HMP Channings Wood

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> • there are clear processes and pathways in place to enable staff to make timely onward referrals; and • staff use appropriate clinical assessment and monitoring tools. 	Accepted	<p>Services not commissioned for prison establishments to be escalated to NHS England to ensure referrals for patients can be made timely and care required can be accessed.</p> <p>To communicate to staff via the next staff meeting the established pathway for escalating patients who require specialist services up to Commissioners when care is not available.</p> <p>Healthcare team to undertake bitesize sessions, led by the clinical lead to review monitoring tools available such as MUST, NEWS, Waterlow, in line with National Institute of Clinical Excellence Guidance.</p>	<p>Regional Manager /Dept Regional Manager</p> <p>Clinical Lead</p> <p>Clinical Lead</p>	<p>30th July 2022</p> <p>15th July 2022</p> <p>31st July 2022</p>
2	The Head of Healthcare should ensure that all healthcare staff receive training on the Mental Capacity Act and that staff	Accepted	All healthcare staff will be given protected time to complete Mental Capacity Act (MCA) and Deprivation of Liberties Safeguarding (DOLS) e-learning as part of the mandatory training required.	Clinical Leads	30 th August 2022

	know when and how to assess mental capacity.		<p>This will be monitored monthly via the Learning Management System (LMS) Training platform to ensure compliance is being met.</p> <p>A learning scenario will take place via a session with staff to review a situation with assessing mental capacity of patients and discuss against Practice Plus Group (PPG) policy what actions would be taken. This will be delivered through the Local Incident Review Group.</p> <p>The Mental Capacity Policy will be re circulated to staff and promoted through staff handovers throughout July 2022.</p>	<p>Safeguarding Lead</p> <p>Clinical Lead</p> <p>Clinical Lead</p>	<p>31st July 2022</p> <p>31st July 2022</p> <p>30th July 2022</p>
3	The Head of Healthcare should ensure that healthcare staff are compliant in the correct level of safeguarding training in accordance with their roles as set out in the Royal College of Nursing (RCN) Intercollegiate Document for 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018).	Accepted	<p>Face to face training has now been re-instated for all staff through Covid-19 recovery for HMP Channings Wood healthcare team.</p> <p>All healthcare staff will be given protected time to complete the necessary safeguarding training required for the role they are in, which forms part of the mandatory training required. This will be monitored monthly via the LMS Training platform to ensure compliance is being met.</p>	Safeguarding Lead	30 th August 2022
4	The Head of Healthcare should ensure the local operating policy for managing omitted doses of medication is reviewed and includes more specific and clearer guidance	Accepted	HMP Channings Wood Omitted Medication Local Operating Procedure will be reviewed via the Local Medicine Management meeting with the HMP Channings Wood Team alongside this incident.	Pharmacy Operational Manager and Clinical Lead	31 st July 2022

	to the Pharmacy Team on the management (including when to alert the GP) of in-possession medication that has not been collected.		Any changes or amendments to the local operating procedure will be ratified through the Local Medications Management Meeting and shared through the Local Quality Delivery Board.		
5	The Head of Healthcare should ensure that healthcare staff follow the protocols for clinical escalation as per NEWS2 and sepsis pathways.	Accepted	Head of Healthcare will ensure that they provide refresher training to the staff to assist in identifying the appropriate action in relation to an abnormal NEWS2 score and how to escalate concerns. This will be audited as part of our PROTECT audit under 'tackle abnormalities' The audit is part of our annual audit cycle undertaken four times a year.	Clinical Lead	30 th August 2022
6	<p>The Governor and Head of Healthcare should:</p> <ul style="list-style-type: none"> • review the two incidences in November 2021 where the HCA thought that prison staff gave her authority to move Mr Roalfe out of bed: and • identify what training is needed so there is clear understanding of the lawful authority of prison staff, and when the Mental Capacity Act 	Accepted	<p>The two incidents will be discussed and analysed at the next Safer Custody meeting which form recommendations to be reviewed and necessary actions agreed collectively through the next LQDB (Healthcare & Governors) Meeting and review the themes within the narrative.</p> <p>Review a joint approach for staff to access MCA Training together both HMPPS and PPG to ensure all staff understand the roles required when managing patients. This will also be included in the next LDBQ meeting.</p>	<p>Governor and Head of Healthcare</p> <p>Head of Business Assurance & Head of Healthcare</p> <p>Head of Safety & Equality</p>	<p>Safer Custody meeting-11 July 2022.</p> <p>LDBQ-21 July 2022</p> <p>31 July 2022</p>

	should be used instead, or in parallel.		Any concerns regarding prisoners having mental health issues which have a likelihood of the requirement for the Mental Capacity Act to be used, they will be recorded as a complex case and their circumstances and care will be discussed at the weekly Safety Intervention meeting with any concerns, decisions and actions recorded in those minutes.		31 July 2022
7	The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.	Accepted	The contingency plans for a death in custody will be amended to include the nomination of a responsible person to ensure all evidence relevant to a death in custody is retained and that evidence made available to the PPO in accordance with PSI 58/2010. All evidence secured will be logged and secured-this will be monitored via the Monthly Safer Custody meeting, with assurance recorded in the minutes of the meeting.	Head of Security & Head of Safety & Equality	31 July 2022