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

Mr Shahrooz Ghassemian on 21 June 2021 at HMP Wandsworth

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that: •ACCT case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate; •staff set specific and meaningful ACCT support actions that are aimed at reducing prisoners' risks to themselves and review them at each case review; and •staff should complete post-closure ACCT reviews in line with PSI 64/2011.	Accepted	In April 2023 the prison introduced the single case manager model for ACCT in order to improve the quality of ACCT documents by providing a consistent manager responsible for each individual at risk. The introduction of this approach included reminder guidance about the importance of multidisciplinary participation in ACCT reviews and ACCT case management, and the importance of support actions being specific, meaningful and regularly reviewed. The introduction of the single case manager model also means that the case manager will be responsible for completing post-closure ACCT reviews, which should provide greater accountability for the completion of these closure reviews. The completion of ACCT reviews and ACCT post-closure reviews is monitored daily by managers. The prison has also introduced a shared database as part of the single case	Head of Safety HMPPS	Completed

			manager model, which can be accessed by all case reviewers and managers. Guidance around the completion of mandatory quality assurance checks was re-circulated as part of the guidance on the new case management system, and upskill sessions have been delivered to managers on completing these checks. The completion of quality assurance checks is also monitored through the safety meeting and any issues identified during the quality assurance process are recorded and addressed. There are a number of actions available if ongoing issues are identified with ACCT management, ranging from additional training and support being provided to staff through to performance management measures.		
2	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, and start ACCT procedures when indicated.	Accepted	ACCT v6 was introduced nationally in July 2021 and included training sessions for staff (operational and partner agencies) covering their responsibilities to identify prisoners at risk of suicide and self-harm. They also included guidance on how to use ACCT documents. Refresher awareness sessions have been delivered to staff in March and April 2023 during Wednesday training days. The sessions have included supporting prisoners at risk of suicide and self-harm, identifying risk and sharing relevant risk information.	Head of Safety HMPPS	Completed

			Information about the actions to take on opening an ACCT was circulated to all staff in February 2023, and individual support sessions were delivered by the Standards Coaching Team on ACCT management in February, March and April 2023.		
3	The Governor and Head of Healthcare should ensure that staff manage prisoners appearing in court by video link in line with national instructions, including that: •prison records (NOMIS) are updated with details of the hearing and the outcome; •any information indicating a risk of suicide and self-harm is shared with relevant staff before the hearing; and •following the hearing, staff consider any new information about risk and start ACCT procedures when indicated.	Accepted	The process for prisoners attending court via video link was last reviewed in May 2023. A questionnaire has now been introduced in order to capture and record relevant risk information. Unfortunately, because of the way video link court hearings operate, knowing when a prisoner has had a change of status immediately after their appointment is reliant on self-disclosure. The updated process requires that, if a prisoner is subject to a change of status, staff must advise healthcare so that a screening can be completed and consideration can be given as to whether there has been a change in risk. A database has been introduced to capture disclosed outcomes from video link court hearings as well as the name of the healthcare member of staff who has been notified and when they were notified of a change of status. Additionally, every prisoner has a case note added to NOMIS detailing what happened during the court hearing, how the prisoner presented and that a handover has been provided to wing staff. Information disclosed by	Head of Operations HMPPS	Completed

			the prisoner regarding outcomes is reviewed once the outcome is received from the court. The Head of Operations carries out a monthly quality assurance check on a sample of cases to ensure that the process is being followed correctly.		
4	The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.	Accepted	Following a review of the key work scheme at HMP Wandsworth, a new approach is being trialled in order to provide prisoners with as much support as possible whilst the prison is unable to deliver key work in line with national expectations due to resourcing challenges. The scheme has been opened up to all staff that have regular interactions and meaningful conversations with prisoners. This includes offender management unit (OMU) staff who see prisoners during the OMU surgeries and can now carry out a keywork session and assist with resolving any issues or concerns raised by prisoners. Opening up the scheme in this way has allowed the allocation of key workers which was not always possible to do consistently due to staffing levels. Key work sessions will be quality assured on a monthly basis by the Head of Offender Management Delivery to see if staff are accurately capturing information provided by	Head of Offender Management Unit HMPPS	Ongoing

			prisoners, as well as recording any follow-up action. The prison will continue to carry out welfare checks for complex and vulnerable prisoners until it is able to deliver key work in line with national expectations.		
5	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies.	Accepted	A notice to staff (NTS) was reissued in August 2021 reminding staff of their responsibilities during medical emergencies, including the importance of using the correct emergency codes and that staff enter cells as quickly as possible when it is safe to do so. This NTS is re-issued on a quarterly basis as part of the prison's local communications strategy. In addition, the communications team issued emergency response reminder cards to staff in September 2021.	Head of Safety HMPPS	Completed
6	The Head of Healthcare should ensure that prisoners are kept informed of the status of their referrals to healthcare services, particularly when referrals are rejected. Information about repeated referrals should be clearly recorded and identify follow-up action.	Accepted	Referrals into healthcare services are triaged daily and allocated to the most appropriate clinician or team to ensure that needs are met in a timely manner and within service specification timeframes. The mental health service has undergone service transformation and the referral process has been reviewed to ensure that referrals are not rejected inappropriately. Each referral is triaged by the team to ensure that repeat referrals are minimised and referrals are	Head of Healthcare Oxleas NHS Foundation Trust	September 2023

			not rejected without being signposted or followed-up. Referrals and waiting lists are reported on weekly and reviewed in the monthly Clinical Governance and Local Delivery Board meetings. Currently the healthcare team are not able to respond to referrals via the CMS kiosk used by prisoners to request appointments, but from Summer 2023 all healthcare services will be provided from a new bespoke healthcare building where there will be the ability to respond directly to appointment requests. All self-referrals will be responded to directly once this system is in place.		
7	The Governor and Head of Healthcare should ensure that pharmacy teams are notified when ACCT procedures are started and that they complete an in-possession medication risk assessment.	Accepted	ACCT alerts for prisoners are added promptly to NOMIS. All new ACCTs are listed on the daily briefing sheet which is accessible for all directly employed staff and partners, including healthcare, and all newly opened ACCTs are discussed each morning at a multidisciplinary meeting. In addition, the healthcare admin team sends a daily list of all open ACCTs to the pharmacy team to ensure that all relevant in-possession risk assessments are updated.	Head of Safety HMPPS Head of Healthcare Oxleas NHS Foundation Trust	Completed
8	The Governor should ensure that prison staff provide all relevant information requested by the	Accepted	A team meeting has been held for safer custody and security staff where they will be briefed on the importance of providing all relevant	Head of Safety and Head of Security	Completed

	Prisons and Probation Ombudsman's office, in line with PSI 58/2010.		information to the Ombudsman in a timely manner.	HMPPS	
9	The Governor should review the provision of CCTV footage and ensure the system works and is able to provide footage to relevant stakeholders, including the Ombudsman.	Accepted	The team meeting for safer custody and security staff regarding the importance of providing all relevant information to the Ombudsman also covered the need to secure copies of CCTV footage at the earliest opportunity. Additionally, there is an ongoing project to repair CCTV issues across the prison.	Head of Safety and Head of Security HMPPS	Completed
10	The Governor should ensure that the staff named in this report are given the opportunity to read this initial report in line with paragraph 1.11 of PSI 58/2010.	Accepted	The report has been shared with named staff and the Ombudsman's findings discussed.	Head of Safety HMPPS Head of Healthcare Oxleas NHS Foundation Trust	Completed