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

## Mr Akhtar Hussain on 08/07/2021 at HMP Manchester

| Rec No | Recommendation | Accepted / Not accepted | Response Action Taken / Planned | Responsible Owner and Organisation | Target Date |
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| 1 | The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm, including that:<br><br>• segregation unit staff consider and record all the known risk factors and triggers of a segregated prisoner, including environmental factors;<br><br>• monitor changes in the prisoner's behaviour or circumstances when determining the risk of suicide and self-harm; and<br><br>• start ACCT procedures when indicated. | Accepted | In order to ensure that all staff are aware of their responsibilities, the Head of Safer Custody will hold a briefing with all segregation staff to upskill them around their responsibilities to monitor all segregated prisoners for signs of increased risk and to start ACCT procedures when indicated. Processes are in place at HMP Manchester for segregation staff to routinely monitor risks and triggers for those prisoners who are located in the segregation unit. They make daily entries for each segregated prisoner which cover their mood, access to regime and any change to the prisoner's circumstance.<br><br>Where there is a change in risk, such as a new ACCT being opened, a new segregation algorithm is completed and signed by a senior manager. | Head of Segregation, HMPPS | Completed |

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| 2 | The Governor should ensure that staff use force in line with national guidelines, including that:<br><br>• planned use of force is only used when it is reasonable and necessary, and only as a last resort when all other means of deescalating the incident have been repeatedly tried and failed;<br><br>• all staff wear and switch on body-worn video cameras during planned use of force interventions;<br><br>• staff remain professional and do not use inappropriate language; and<br><br>• CM A and SO B receive additional advice and guidance on the lawful use of force and de-escalation techniques. | Accepted | HMP Manchester has introduced weekly use of force assurance meetings. A panel of senior managers and use of force specialists review all use of force incidents that involve PAVA, batons, planned use of force and a 20% random selection of other incidents. Where issues are identified, these are addressed with the individual and their line manager made aware. If the panel identifies that body worn cameras have not been activated or that staff use unprofessional language then this is challenged and documented.<br><br>Separately, staff have been reminded via staff briefings that they should wear and switch on body-worn video cameras during planned use of force interventions. They have also been reminded of the expectation to remain professional at all times and not to use inappropriate language. Additionally a template challenge letter has been developed which is issued on behalf of the Head of Safer Custody to staff who do not turn on body worn video camera during documented incidents..<br><br>The CM and SO identified will be provided with additional advice and guidance on the lawful use of force and de-escalation techniques when the report is shared with them. | Use of Force lead and Head of Safer Custody, HMPPS | Completed |
| 3 | The Governor should ensure that staff manage prisoners held in segregation in line with national guidelines, including that: | Accepted | HMP Manchester holds quarterly segregation monitoring and review group meetings which review all instances of segregation in order to provide assurance that all prisoners held in | Head of Segregation, HMPPS | Completed |

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| | • segregation is used appropriately, in line with Prison Rules, and with the authority of an operational manager;<br><br>• each prisoner is assigned a designated officer responsible for their welfare;<br><br>• staff engage in purposeful dialogue with each prisoner at least three times a day, and that this is recorded in the prisoner's history sheet; and<br><br>• prisoners are able to access all aspects of the regime every day and have access to basic personal property and distraction materials. | | segregation are segregated in line with HMPPS policy and with the authority of an operational manager. Where any issues are identified, these will be discussed with the individual and their line manager made aware.<br><br>On a daily basis every prisoner held in segregation will talk to segregation staff as well as to the duty governor, a chaplain and a healthcare professional. All purposeful dialogue is documented in the prisoner's history sheet.<br><br>The process of requesting access to all aspects of the regime is explained to all prisoners arriving on the Segregation Unit. Every morning each prisoner is asked to confirm which aspects of the regime they would like access to that day.. The regime for all prisoners in segregation is being reviewed by the incoming new Head of Function with a view to ensuring all prisoners have access to daily showers and phone calls.<br><br>The prison has plans to assign a key worker to all segregation prisoners as part of the wider key worker action plan. Currently, this is not achievable due to staffing constraints, but is part of the ongoing plan to bolster key work for prisoners at HMP Manchester.<br><br>The prison has clarified the process for moving basic personal property from the wing to the segregation unit so that staff are clear about who is responsible. Prisoners held in segregation have access to reading materials and are also offered distraction materials such as colouring | | |

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| | | | and origami items. Prisoners are also allowed basic personal items and religious items. | | |
| 4 | The Governor and Head of Healthcare should ensure that healthcare professionals completing segregation unit health screens have access to the prisoner's medical history and are always given the opportunity to speak to the prisoner. | Accepted | All segregation algorithms are now the responsibility of Hotel 7 (MHIT), who review clinical notes for historical/current medical and mental health history. This process is well embedded into the healthcare culture.<br><br>All segregation and healthcare staff are aware that access to healthcare must be facilitated before signing of segregation algorithms and the practice of them being signed elsewhere has ceased. | Head of Healthcare, GMMH | Completed |
| 5 | The Governor should commission a disciplinary investigation into the actions of segregation unit staff on the morning of 5 July 2021. | Accepted | An internal investigation has been completed into the actions of segregation staff on 5 July 2021. | Governor, HMPPS | Completed |
| 6 | The Governor should ensure that segregation unit staff complete their duties satisfactorily and in line with local and national requirements, including that:<br><br>• staff observe prisoners subject to cellular confinement at least once every hour;<br><br>• staff observe prisoners at roll checks and take appropriate action if they have concerns for a prisoner's welfare; and | Accepted | Segregation unit staff have been reminded during staff briefings and supervision sessions that prisoners serving cellular confinement must be observed at least once every hour and to document this on the daily checks forms.<br><br>Roll checks are completed at various key times throughout the day and are monitored via CCTV. Where concerns are identified that a roll check has not been conducted in line with policy, this will be discussed with the member of staff. Staff briefings and supervision sessions have been held with segregation unit staff to remind them that they must observe prisoners at roll checks and take appropriate action if they have concerns | Head of Safer Custody and Head of Segregation, HMPPS | Completed |

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| | • staff answer cell bells promptly, take reasonable steps to answer the query and take appropriate action if they have concerns for the prisoner's welfare. | | for a prisoner's welfare. Staff have been reminded that any welfare concerns should be documented in the Daily Observations sheet and on NOMIS.<br><br>All staff were reminded of the importance of answering cell bells promptly via a notice to staff that was issued in December 2023. The prison is exploring whether it is possible to obtain access to the call system so that regular spot checks of cell bell response times can be introduced. | | |
| 7 | The Governor should ensure that managers conducting disciplinary hearings impose punishments in line with local tariff guidelines and take into consideration mitigating circumstances when considering awarding periods of cellular confinement. | Accepted | The new HMPPS Adjudication Policy Framework is being implemented at HMP Manchester, which will allow adjudicating governors to consider the new payback punishment options and rehabilitative activities. As a result, there will be a full local tariff review and wider discussions will be held with all adjudicating governors to increase their awareness of the adjudication process. They will be reminded to take into account any mitigating circumstances when considering awarding periods of cellular confinement. | Head of Segregation, HMPPS | October 2024 |
| 8 | The Governor should ensure that managers imposing punishments of cellular confinement fully consider the likely impact on the health and welfare of the prisoner, including referring the prisoner to the mental health team, where appropriate. | Accepted | Adjudicating governors have been reminded to consider the likely impact on the health and welfare of the prisoner when imposing punishments of cellular confinement and to ensure that a mental health referral is made where this is considered appropriate. | Head of Safety, HMPPS | Completed |
| 9 | The Prison Group Director for the Long Term and High Security Estate should take steps to satisfy himself | Accepted | The Prison Group Director (PGD) will satisfy himself that actions have taken place through | Prison Group Director for Long Term and High | Completed |

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| | that all staff at HMP Manchester understand their responsibilities during medical emergencies, including calling an immediate emergency code when there is a threat to life. | | regular discussions with the Governor and Performance & Assurance Meetings.<br><br>The prison has completed comprehensive work to raise staff awareness of their responsibilities and how to make an emergency call for assistance when there is a threat to life. This includes regularly publishing a Notice to Staff to reinforce the importance of calling a medical emergency response code without delay, discussion at a full staff briefing in October 2022, and the issue of pocket cards to staff which explains when to use the relevant codes. Emergency response codes are also displayed for staff to see.<br><br>The PGD tasked his Group Safety Team to dip test this requirement, and they were able to offer assurance they had found improvements with staff having a good understanding of emergency response codes and the importance of calling for assistance immediately. The PGD has tasked his Safety Team to undertake periodic dip tests to provide continued assurance. Any deficiencies will be raised through the PGD. | Security Estate (North) / Group Safety Lead, HMPPS | |
| 10 | The Head of Healthcare at HMP Buckley Hall should ensure that all prisoners identified as having a severe and enduring mental illness have comprehensive care plans. | Accepted | All patients with severe and enduring mental health issues have comprehensive care plans in place. Random care plans are audited on a monthly basis. Operational management held by the head of healthcare with Greater Manchester Mental Health NHS Foundation Trust (GMMH) (Mental health provider) on a monthly basis to ensure compliance. | Head of Healthcare, Greater Manchester Mental Health NHS Trust (GMMH) | Completed |

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| | | | All patients with severe/enduring mental illness are monitored through QOF (Quality and Outcomes framework) and care plans developed/updated when required | | |
| 11 | The Heads of Healthcare at HMP Manchester and HMP Buckley Hall should ensure that:<br><br>• liaison between prisons takes place when prisoners with a history of severe and enduring mental illness are transferred to Manchester and that the outcome is fully documented in the prisoner's medical records;<br><br>• all prisoners identified as requiring an urgent mental health assessment are assessed promptly and within 48 hours; and<br><br>• all prisoners with a significant and current mental illness are discussed at the weekly mental health multidisciplinary meeting to ensure continuity of care. | Accepted | Initially the mental health team at HMP Buckley Hall will attempt to make contact by phone to the mental health at the receiving prison. This telephone encounter would be documented in the patients records on SystmOne. An email is also sent to a generic mental health inbox at the receiving prison providing a full handover of the patient's care. A task function is now available through SystmOne which allows any critical information to be shared with the receiving prison.<br><br>All prisoners are seen by the mental health team within 48 hours of arrival at HMP Buckley Hall. The reception nurse will task the mental health group though SystmOne to alert them of any patients who require an urgent assessment from the mental health team. These tasks are all saved within patient's records.<br><br>Following this death, a monthly MH Team managers meeting was set up with all the GMMH prisons. There is an agreement that this is in practice and a handover will take place. There is also an emphasis that if a receiving team does not receive a handover that they are proactive to | Heads of Healthcare at HMP Buckley Hall and HMP Manchester, GMMH | Completed |

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| | | | contact the sending prison for this. Where transfers fall out of GMMH remit we do not have control over what processes they have but GMMH prisons are aware that they are required to contact the prison for a handover.<br><br>At HMP Manchester specifically, Prior to covid restrictions prisoners would be seen and then discussed at one of the 3 MDT weekly meetings. An action that was implemented was that if a prisoner had not yet been assessed but there were significant concerns that there would be a discussion and handover of the limited information to the Psychiatrist at the MDT meeting.<br><br>All prisoners at HMP Manchester are seen by the mental health team in reception for a screening as per NICE guidance 66. At the time of Mr Akhtar's death the national guidance was men transferring from other sites were required to reverse cohort for 10 days and there was limited face to face contact which also included clinical contact. Since covid these restrictions have been reviewed and the prison has returned to the status quo position of screening all prisoners in reception. | | |
| 12 | The Governor and Head of Healthcare at HMP Manchester should ensure that a copy of this report is shared with all staff named | Accepted | The report will be shared with staff named in the report and the findings discussed with a senior manager. | Head of Safer Custody, HMPPS | Completed |

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| | in this report and that a senior manager discusses the Ombudsman's findings with them. | | | | |