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

## Mr John Reid on 10 August 2022 at HMP Winchester

| Rec No | Recommendation | Accepted / Not accepted | Response Action Taken / Planned | Responsible Owner and Organisation | Target Date |
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| 1 | The Governor should review the local Emergency Call Out Protocol 2018 and ensure that there are no unnecessary delays in admitting and discharging ambulances. | Accepted | The Head of Operations has reviewed the Emergency call out protocol to ensure that there are no delays in admitting and discharging ambulances at the prison gate. | Head of Operations HMPPS | Action completed February 2024 |
| 2 | The Head of Healthcare should ensure that in a medical emergency, the patient is moved to an appropriate area where they can be fully assessed and treated. | Accepted | Emergency care is a priority for the healthcare team along with safety of both patient and staff.<br><br>Healthcare staff will carry out a dynamic risk assessment on attendance to every emergency and in line with ILS training standards of the environment the patient is in to assess both patient and staff safety.<br><br>Where the environment is unsafe or not appropriate healthcare staff will request that the patient is moved to an appropriate area to allow care to be provided, this move will be carried out jointly between healthcare and prison staff under supervision of the orderly officer. | Head of healthcare Practice Plus Group | February 2024 |

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| | | | The healthcare team will be reminded of the need for such risk assessment as part of the site Quality assurance and Patient safety meetings.<br><br>The healthcare team will also be reminded of the need for clear and direct communication with prison colleagues to allow care to be provided quickly and appropriately.<br><br>In situations where it is not possible to move the patient for either clinical or operational reasons a clear plan will be formulated between the Orderly officer and the member of the healthcare co-ordinating the clinical aspect of the incident. | | |
| 3 | The NHS Commissioner for South Central should write to the Ombudsman, setting out how they intend to improve clinical record keeping at HMP Winchester. | Accepted | PPG will take ownership of this action at site level and write to the Ombudsman outlining action to be taken with regarding to appropriate clinical documentation. This letter will then be reviewed and counter signed by the NHS England Senior commissioner in acknowledgment of the agreed actions.<br><br>Actions will include review of this incident and action planning at site led Patient safety Incident review meetings and quality assurance meetings.<br><br>It will be a standing agenda item for all 1 – 2 – 1's and an agreed target within all PCR's (performance conversation records) for clinical staff.<br><br>The clinical matron will carry out a session on a Wednesday training afternoon for all clinical staff around the NMC | Head of Healthcare Practice Plus Group<br><br>NHSE Senior commissioner | On-going |

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| | | | standards for record keeping, this will be repeated until all staff have been captured.<br><br>Alongside this PPG provide annual mandatory record keeping modules to healthcare staff. Record keeping and compliance are monitored through the PPG PROTECT audit tool. An audit that has been designed from DIC recommendations.<br><br>Audits are monitored through PPG National and local governance platforms, contract retention, and partnership board meetings. | | |
| 4 | The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:<br><br>• the medical information accurately reflects the prisoner's current clinical condition and impact on their ability to escape unaided; and<br><br>• operational staff take account of this information and fully document all decisions concerning the use of restraints. | Accepted | In January 2023 the PPO were invited to attend HMP Winchester to deliver a presentation to the Senior Management Team on their findings on the use of restraints and the Graham Judgement.<br><br>This event increased awareness of the Graham Judgement, ensuring managers are aware of the need to take into account healthcare staffs' evaluation of the prisoner's clinical condition when considering their ability to escape; in order to properly inform cuffing arrangements on the Escort Risk Assessment.<br><br>PPG have appointed an Early days in custody lead (EDIC) within reception and early days. They are responsible in ensuring appropriate information is available to operational staff and Governors to safely assess the use of restraints. | Head of Safety HMPPS<br><br>Head of Healthcare Practice Plus Group | Completed<br><br>Completed |

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| | | | From a healthcare perspective, the Clinical Matron and EDIC are responsible for effective communication between Secondary care and HMPPS staff whilst a patient is in the care of an external provider. | | |
| 5 | The Governor should ensure that staff complete all relevant sections of a prisoner's personal records and wing documents; and fully document all significant interactions and decisions. | Accepted | Reception and induction staff have received awareness-raising sessions on risk identification, and the need to ensure that all relevant information is recorded on NOMIS, including the use of Alerts. Refresher training will be regularly delivered to all staff by the Group Safety team.<br><br>Notices to Staff have been circulated to raise awareness of the importance of recording all contact with prisoners on NOMIS case notes, and risk information on NOMIS Alerts. During Early Days in Custody, First Night Induction staff now complete and record all relevant information on NOMIS case notes and when Basic Custody Screening 1 is completed another NOMIS entry is generated.<br><br>Keywork is currently being implemented, with prisoners deemed at risk due to their circumstances, for example complex cases, those held in the CSU and those on open ACCTs and CSIPs being prioritised. This will cover approximately 30% of the population and will be expanded until all prisoners are receiving keywork contact. Staff are expected to record all key work on NOMIS, and the Head of OMU will implement a system for checking the quality of keywork entries. | Head of Induction HMPPS<br><br>Head of Safety<br><br>Head of Residence and Head of Offender Management Unit (OMU), HMPPS | Completed<br><br>Completed February 2024 (to be re-published annually)<br><br>February 2024.<br><br>March 2024 |