

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

Mr Matthew Braben on 06/08/2021 at HMP Wormwood Scrubs

Rec No	Recommendation	Accepted/ Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> • staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present, • staff start ACCT monitoring procedures when a prisoner self-harms or expresses suicidal thoughts; and • staff share all information that affects risk. 	Accepted	<p>From July 2021, following the roll out of ACCT version 6, risks and triggers awareness sessions and training on how to use ACCT to support prisoners at risk of suicide and self-harm was delivered to staff. The awareness sessions covered how to identify risks and triggers and the importance of considering these along with a prisoner's presentation. Staff were also reminded to consider starting ACCT monitoring procedures when a prisoner self-harms or expresses suicidal thoughts.</p> <p>Additional risks, triggers, and protective factors awareness sessions have been delivered to key staff and will now form part of the ongoing training provided to staff. This training will also be provided to healthcare staff to improve their knowledge of risks and triggers and to improve the sharing of information relevant to risk.</p> <p>In October 2021 a notice to staff (NTS) was published regarding risks and triggers to re-</p>	<p>Head of Safety HMPPS</p> <p>Head of Healthcare PPG</p>	November 2022

			<p>emphasise the learning from the awareness sessions.</p> <p>Practice Plus Group (PPG) have arranged for applied suicide intervention skills training (ASIST), which will take place in November 2022. Those identified as needing this training will be in attendance.</p> <p>An urgent training need was identified for an individual member of healthcare staff following Mr Braben's death and they attended Suicide and Self Harm (SASH) training at HMP Pentonville in January 2022.</p> <p>PPG carried out an audit into the sharing of risk information and relevant learning has been shared with key individuals. PPG also takes part in an annual audit of processes in relation to suicide and self-harm.</p>		
2	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> •prisoners are assessed by a GP when primary mental health services are required, • if a patient stops engaging with any mental health provider in the prison, this is discussed with the wider team, 	Accepted	<p>In April 2022 the Head of Healthcare implemented a letter that is sent to patients when they are discharged from mental health services. A task via SystmOne is also sent to the GP group to inform them that the patient is now under their care as opposed to mental health services. The GP will follow these referrals up with a face to face visit if required.</p> <p>The Atrium prison service discharge policy has been updated to ensure that when an individual</p>	Head of Healthcare PPG	July 2022

	<ul style="list-style-type: none"> • waiting lists for mental health services are managed appropriately in accordance with needs and risk; and • all healthcare staff ensure their recording keeping is in line with guideline 		<p>declines counselling and/or is discharged from the service, the therapist is required to task the mental health in-reach team (MHIT) to inform them of this. A member of the Atrium team (ideally the clinical or prison lead) now attends the referral meeting weekly.</p> <p>In June 2022 there is a plan for several training sessions to be delivered to healthcare staff in regard to escalating risk, checking referrals and managing waiting lists.</p> <p>An annual documentation audit is carried out to check that record keeping is in line with guidance. This is shared with the wider team and any learning is identified.</p>		
3	<p>The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:</p> <ul style="list-style-type: none"> • understand and use the appropriate emergency code when they discover a medical emergency; and • staff enter cells as quickly as possible in life-threatening situations where it is safe to do so. 	Accepted	<p>Staff responsibilities during medical emergencies have been prioritised as a key part of the safety and healthcare teams' messaging to all staff.</p> <p>A NTS was re-issued in September 2021 reminding staff of their responsibilities during medical emergencies. Additionally, pocket reminder cards that include the correct codes to be used in a medical emergency have been distributed to staff and are available in key locations.</p> <p>In March 2022 a NTS was re-issued in relation to making a dynamic risk assessment for entering a</p>	Head of Safety HMPPS	Completed

			cell in a life-threatening situation, and this emphasised the importance of preservation of life.		
4	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.	Accepted	<p>HMP Wormwood Scrubs is planning an emergency response awareness week in September 2022. This will include prison and healthcare staff working together in scenarios, intense training sessions, staff briefings and an opportunity to discuss and ask questions.</p> <p>The Royal College of Nursing (RCN) guidelines for when not to perform CPR has been recirculated to all healthcare staff. All clinical staff undergo immediate life support training each year which includes when not to commence CPR.</p>	Head of Healthcare PPG	September 2022
5	The Governor and Head of Healthcare should ensure that this report is shared with all staff named in it and that they are given the opportunity to reflect on the learning involved.	Accepted	<p>The report and its findings will be shared with all named staff.</p> <p>There was a group supervision in May 2022 which was delivered by our Patient Safety and Clinical Quality Lead and the report was sent directly to all those named in the report. All staff were also given the opportunity to participate in one to one supervision regarding this death in custody.</p>	Head of Safety HMPPS Head of Healthcare PPG	July 2022