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

Ms Davina Canning alias Mr Arthur Canning on 29 July 2023 at HMP Hewell

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should review the quality and compliance with policy of ACCT management in the previous 12 months, identify any improvements required, and devise a plan to deliver those improvements.	Accepted	A review of the quality and compliance with ACCT case management procedures over the previous 12 months will be undertaken by the safer custody team, with support from regional safer custody colleagues. This will include reviewing compliance with the nationally mandated ACCT quality assurance process, relevant safer custody governance data and regional safer custody advisory reports. The prison will then produce an action plan outlining areas for improvement with progress monitored as part of the safer custody meetings.	Head of Safety HMPPS	December 2024
2	The Head of Healthcare should ensure that prisoners who present with persistent and challenging behaviours are assessed according to their level of risk and need, with consideration given to their most suitable location.	Accepted	HMP Hewell acknowledges that all prisoners with persistent and challenging behaviours. In response to the action we can provide assurance that there are robust pathways in place at HMP Hewell support individuals with persistent and challenging behaviours	Head of Healthcare PPG Team Manager, Inclusion MPFT	November 2024

			All prisoners are initially assessed in reception by a clinician on admission to Hewell and additionally assessed by EDIC which includes a mental health nurse on the induction wing within 48 hours. All assessments were done within the correct time frame in relation Mr Canning. Mr Canning was seen by EDIC and ISMS(Healthcare) staff, a tag and task referral was sent to Inclusion within the agreed timeframe A task was also sent to the GP and MPCC in relation to a medication review. This again followed the correct process and timeframe. The Inclusion Registered Nurse Practitioners will hand over any concerns at a daily MPFT allocations meeting. Mr Canning was handed over and a care co-ordinator was allocated. Mr Canning would have had a face to face first meeting within 10 days to formulate a care plan however as he was on ACCT document he was seen then by the team. Any immediate concerns relating to self-harm or suicide identified can any health professional, an ACCT would be opened which would be attended by care co-ordinators if they are under the MH team. If an initial ACCT is opened a Registered professional must attend even if they aren't already under the team. If they are under the		

			Inclusion team the care coordinator will attend to help manage risk appropriately. Any patients at HMP Hewell identified as needing intensive support and monitoring are discussed as part of an MDT (weekly Thursdays) and allocated to the Targeted Care Pathway (TCP) based on house block 4. As all patents are assessed individually, It is possible for a patient on the TCP who have good support on main location to remain stable in their original location. At times it is recognised that moving them can have an adverse effect. Mr Canning's assessment did not evidence the need for TCP, there was no indication referral to external hospital was required. To support patient safety HMP Hewell has a variety of platforms where individuals can be discussed dependent on their identified need. There is a robust weekly Safety Intervention Meeting (SIM) which is attended by Healthcare, Inclusion and the prison. Patients can also be discussed at MDT, Integrated Safety Huddle (Tuesday) and MPCCC (Thursday) to ensure all aspects of the difficulties they are facing are identified and understood. Mr Canning was discussed at MPCC, the team responded to any concerns raised, there was good joint working between healthcare and the prison to review the ACCT document. Having		

			reflected on the PPO action we have evidenced here we have systems and process in place to manage patients with persistent and challenging behaviours.		
3	The Head of Healthcare should ensure that all emergency response staff attend medical emergency codes immediately.	Accepted	The response radios are carried by healthcare staff 24 hours a day, when a code is dispatched over the prison net healthcare staff verbally respond to the code and advise the control room that they are on route to the scene. The night staff were located in the healthcare at the time of the code blue which is at the other side of the prison. The staff collected the emergency bag and made their way to the wing immediately. On a night healthcare staff have to open and lock gates behind them which adds to the response time, during the day prison staff will support with this. All healthcare staff are aware that they need to make their way an incident swiftly, we do not encourage healthcare staff to run to incidents as they may be required to undertake CPR for some time when they arrive at the incident. This can be very physically demanding for staff depending on how long it takes for an ambulance to arrive on scene. The incident was discussed in detail at the clinical case review, site staff and regional leads were present. From speaking to the staff	Head of Healthcare PPG	November 2024

			involved, taking into account the incident occurred at night and also the geography of the establishment we are assured that the staff responded within a proportionate time. The Nurse and HCA who were involved in the resuscitation attempt for Mr Canning were both required to undertake additional training following this incident,		