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

Mr Roy Sinclair on 25 November 2023 at HMP Woodhill

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should review the contribution to the ACCT process from mental health nurses for prisoners who have seriously self-harmed, including those not on the mental health team's caseload.	Accepted	The Mental Health team now review and triage new risk incidents as part of their morning briefing process. During the morning briefing, the team identify whether the patient needs to be seen for an updated Mental Health Assessment following the risk incident. If identified by the MDT to be a serious risk incident (self harm by cutting, ligature, overdose fire starting etc) then the patient will be seen by a registered practitioner. Other newly opened ACCT's not identified as needing a Mental Health assessment will continue to be managed as prior, they will be seen by any member of the team.	Head of Healthcare, Central and North West London NHS Foundation Trust	3 months
2	The Head of Healthcare should investigate why a mental health nurse did not assess Mr Sinclair when he returned from hospital after a serious incident of self-harm.	Accepted	Following this incident, practice has been reviewed within the mental health team. It is now practice within the team that all serious incidents of self-harm/suicidal attempts trigger a Mental Health assessment which is carried out by a registered mental health practitioner. The severity of the incident is triaged by the team in their morning briefings.	Head of Healthcare, Central and North West London NHS Foundation Trust	3 months