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

## Mr Ashley Wood on 09/09/2021 at HMP Exeter

| 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 manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:<br><br>• a named consistent case manager chairs ACCT reviews;<br><br>• staff hold an urgent case review when a prisoner's risk increases;<br><br>• a prisoner's family and friends are included in the ACCT process where appropriate;<br><br>• staff hold ACCT reviews as scheduled;<br><br>• staff appropriately question prisoners following an incident of | Accepted | The Head of Safety has implemented supervision sessions for all case coordinators to ensure that staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm and to gain assurance that named consistent case coordinators are chairing ACCT reviews. The supervision sessions also focus on the inclusion of a prisoner's family and friends to ensure that they are included in the ACCT process when appropriate and when consent is given by the individual being supported. Supervision will be continued, and sessions increased to ensure there is an improvement in the quality of ACCT case coordination.<br><br>ACCT quality assurance checks are carried out by the safer custody team in line with the national mandatory quality assurance process. These checks ensure that ACCT reviews are held as scheduled and that case coordinators are challenged if any deficiencies are identified. The | Head of Safety HMPPS<br><br>Head of Healthcare Oxleas | December 2022 |

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| | self-harm or attempted suicide; and<br><br>• staff record and share all information that affects risk. | | quantity of checks carried out increased in October 2022.<br><br>A notice to colleagues (NTC) was published in August 2022 to ensure that staff are aware of the requirement to appropriately question prisoners following an incident of self-harm or attempted suicide. Daily staff briefings and regular communications via the weekly safer custody report will also include reminders and guidance for staff.<br><br>The Head of Safety and Head of Healthcare will provide guidance to all staff on the importance and requirement to share all information that affects risk. Additionally, all healthcare staff will receive local training on ACCT V6.<br><br>Healthcare staff are made available to attend ACCT reviews when they are planned in advance. First ACCT reviews are attended by mental health, with subsequent ACCT reviews attended by the most appropriate healthcare representative to support the individual's care. This is monitored via the ACCT attendance audits which are undertaken monthly and presented through local healthcare quality assurance procedures.<br><br>If healthcare staff are made aware of or identify a change in an individual's risk, this is | | |

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| | | | communicated to the wing supervising officer and will trigger an ACCT review, if appropriate. | | |
| 2 | The Governor should ensure that prison staff inform healthcare staff when a prisoner asks to see them. | Accepted | A NTC has been published to remind all staff of their responsibility to inform healthcare when a prisoner asks to see them.<br><br>Guidance is now also published on the weekly safer custody report which is shared as a global email to all staff. | Head of Safety<br><br>HMPPS | Completed |
| 3 | The Governor and Head of Healthcare should ensure that all staff have received ACCT training and that they are satisfied that staff can appropriately assess a prisoner's risk to themselves. | Accepted | Local ACCT V6 training will be delivered to all staff by the safer custody team throughout the year 2022-23. This will be supported by resources that have been shared by the establishment support team.<br><br>Module 3 of the Safety Skills package (formally SASH modules 1-6) will also feature on the training plan for 2022-23 and will include operational and non-operational staff. | Head of Safety<br><br>HMPPS | February 2023 |
| 4 | The Governor should ensure that incidents of violence, bullying or intimidation are investigated and dealt with in line with local and national policies. | Accepted | CSIP re-rollout began in February 2022 and improvements have been seen in the quality and quantity of referrals. Further guidance in the form of one-to-one and group training sessions will be delivered with a focus on referrals, investigations, and case management. | Head of Safety<br><br>HMPPS | November 2022 |

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| | | | All incidents of violence and intelligence relating to bullying or intimidation will result in a CSIP referral and subsequent investigation with appropriate support provided.<br><br>CSIP guidance will be a feature on the weekly safer custody report and will feature in staff briefings and performance reviews. | | |
| 5 | The Head of Healthcare should ensure that those who are on a waiting list for therapy have access to mental health support in the interim if there is a risk of suicide and self-harm. | Accepted | The mental health team carry out welfare checks for patients who are on the waiting list for psychological interventions if any concerns are raised by the patient or partner agencies. Patients are able to contact the mental health team directly via Kiosk. The mental health team also attend ACCT reviews for any patients who are on a mental health waiting list. In both cases this may result in a review of planned care if required.<br><br>Following the transfer of services to Oxleas NHS Foundation Trust all mental health pathways will be reviewed and new models of trauma-informed care for at-risk patients are expected to be introduced in Summer 2023 following staff consultation and recruitment. | Head of Healthcare<br><br>Oxleas<br><br>Head of Healthcare<br><br>Oxleas | Completed<br><br>August 2023 |
| 6 | The Head of Healthcare should ensure that: | Accepted | Following this incident nursing staff have been reminded by the Lead GP during nursing handovers of the importance of making clear management plans involving senior MDT colleagues if there are clinical concerns regarding | Head of Healthcare<br><br>Oxleas | Completed |

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| | •when a prisoner needs clinical observations these are completed; and<br><br>•staff refer prisoners appropriately to the mental health team. | | a patient, and ensuring that any requested clinical observations are carried out and recorded in order that they can be reviewed by senior clinicians as necessary.<br><br>Record-keeping audits will be introduced by Oxleas NHS Foundation Trust and record-keeping is also addressed by line managers in regular supervision to ensure that any learning requirements are addressed with individuals.<br><br>Healthcare staff now use SystmOne tasks for all referrals in to the mental health team to ensure that referrals are auditable and addressed according to priority. The Head of Healthcare is assured that the task system is used and audited by the mental health team. | Head of Healthcare<br><br>Oxleas<br><br>Head of Healthcare<br><br>Oxleas | June 2023<br><br>Completed |
| 7 | The Head of Healthcare should ensure that all prisoners with learning disabilities are clearly recorded, staff receive relevant learning disability training and follow NHSE/I guidance for prisoners with learning disabilities. | Accepted | Recent updates to statutory mandatory training now includes two new modules for all staff to complete:<br><br>• Autism eLearning<br>• Learning Disabilities eLearning<br><br>There is a learning disability nurse available across the Devon cluster who attends healthcare handovers with updates and care plans for specific patients to support the healthcare team.<br><br>The learning disability nurse carries a caseload across the Devon Cluster. | Head of Healthcare<br><br>Oxleas | November 2022 |

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| | | | Read codes are added to SystmOne records for all learning disability patients so this is clearly available for staff.<br><br>Training sessions on learning disabilities is to be delivered to the full healthcare team at Friday team meetings. | | |
| 8 | The Governor should ensure that the key worker scheme is properly embedded and that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role. | Accepted | HMP Exeter is currently experiencing staffing shortfalls. As a result, key work is being managed in line with the Recovery Management Plan (RMP) with targeted key work being prioritised to prisoners who have been identified as the most vulnerable and those who are in their resettlement phase. As soon as resources allow, key work will be rolled out as per the national guidelines. | Head of Safety and Head of OMU<br><br>HMPPS | Ongoing |
| 9 | 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 | This report has been shared with all named prison staff and they have been given the opportunity to reflect on the learning involved.<br><br>The report has been shared via the local quality assurance and shared with specific healthcare staff via clinical supervision sessions with management support. | Head of Safety HMPPS<br><br>Head of Healthcare Oxleas | Completed |