

Action Plan in response to the PPO Report into the death of Mr Imran Khan on 05/12/2020 at HMP Isle of Wight

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> • ACCT assessment interviews and the first ACCT case review are conducted separately, in line with PSI 64/2011; • ACCT reviews determine the required frequency of conversations with the prisoner, as well as the required frequency of observations; and • ACCT case managers are reminded of the importance of completing the ACCT documentation legibly. 	Accepted	<p>The implementation of ACCT Version 6 (v6) commenced in July 2021 and the updated training has now been delivered to all staff. All Managers and Supervising Officers are also trained in ACCT case management and have access to the new Case Co-ordinator training for ACCT v6. The training reinforces the requirement that the initial case reviews and assessments are two separate processes and should not be combined.</p> <p>The training also reminded staff of the need to determine the appropriate frequency of conversations and observations with the prisoner during all ACCT reviews and that these should be discussed, agreed and clearly documented in the ACCT records during each review.</p> <p>A staff notice was sent to all Case Co-ordinators to reinforce the ACCT requirements and to highlight the learning points from this report. The Case Co-ordinators were then asked to return a signed copy to the Safer Custody team in November 2021 to show that the requirements were read and understood.</p> <p>Monthly ACCT Quality Assurance processes will be maintained by the Senior Managers to identify any deviation from national policy and to provide feedback and further training for staff where required.</p>	Head of Safer Custody HMPPS	Completed

2	The Governor should share this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.	Accepted	The Head of Residence discussed this report and the Ombudsman's findings in a formal meeting with this named member of staff in November 2021 which addressed all of the relevant learning points. All actions following this meeting were also reported to the Deputy Governor.	Head of Residence HMPPS	Completed
3	The Head of Healthcare should ensure that mental health assessments are carried out separately from ACCT case reviews.	Accepted	The Head of Healthcare instructed all staff in October 2021 that primary mental health assessments should be undertaken separately from ACCT case reviews. This will be monitored by the Clinical Lead for Mental Health.	Head of Healthcare and Clinical Lead PPG	Completed
4	The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.	Accepted	This report was shared with the staff member in October 2021 during a meeting with the Clinical Lead for Mental Health and the Head of Healthcare.	Head of Healthcare and Clinical Lead PPG	Completed
5	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> • when staff carry out ACCT checks they vary the times of the checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and • ACCT training is provided to all new staff prior to them taking up a role where they have responsibility for 	Accepted	<p>ACCT Version 6 (v6) awareness training sessions were introduced in July 2021 which all staff have now received. These are being added to the Suicide and Self-Harm (SASH) training package and will be delivered annually as refresher training.</p> <p>ACCT Quality Assurance checks will continue to be undertaken by Senior Managers to ensure that all observations are carried out at irregular intervals and to identify where any further training for staff may be required.</p> <p>A Notice to Staff (NTS) was published in October 2021 to further reinforce the learning from this report and to ensure that all staff are aware of the procedures for observation checks including that they must be at varied times. All staff were asked to</p>	<p>Head of Safer Custody HMPPS</p> <p>Head of Business Assurance HMPPS</p>	Completed

	monitoring prisoners, such as night shifts.		acknowledge that they read and understood the NTS and the Safer Custody team collated these responses.		
6	<p>The Governor should:</p> <ul style="list-style-type: none"> • review the bedwatch log for the day of Mr Khan's death (5 December) and; • remind bedwatch officers of the importance of showing respect and sensitivity to prisoners' families. 	Accepted	<p>An investigation was initiated in December 2020 by a Senior Manager following the events of the 5 December 2020, which included a review of the bedwatch log, which is now completed.</p> <p>All staff were briefed in January 2021 on the requirements of external escorts and of bedwatch duties. Staff were reminded to ensure that they are aware of what is required of them during the external escort and of the professional standards expected whilst on escort duties.</p> <p>An aide-memoir for all bedwatch and escorting officers was produced in October 2021 to serve as a reference guide for staff that are undertaking external escort duties in hospitals. This included the protocols for communication with the next of kin and guidance on the correct escorting process.</p>	<p>Deputy Governor HMPPS</p> <p>Head of Security Intelligence HMPPS</p>	Completed