PPO Action Plan – death of James Maughan at HMP Bullingdon on 11/07/2016				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor should ensure that: • staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons; • all staff receive ACCT training and are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.	Accepted	A notice to staff was issued in October 2016 which reminded all staff of the importance of considering all known risk factors for suicide and self-harm, when assessing a prisoner's risk. This will be re-issued, and an email sent to all Functional Heads and Custodial Managers to direct that a reminder about this requirement is included in their staff meetings and daily briefings. In addition, a notice to staff was published in January 2017 confirming that all staff should consider opening an ACCT if a prisoner expresses feelings of suicide or self-harm. The notice reminded staff of the need to record the detail of the consideration and outcome of any assessment that leads to a decision not to open an ACCT. All new members of staff in prisoner-facing roles have been identified to ensure they receive ACCT awareness with the Safer Custody Team during their Induction period. This will provide guidance on when an ACCT is required, possible risks and triggers for self-harm, and action to take on the discovery of an unresponsive or deceased prisoner. This training will be followed up within three months with a full training session in ACCT procedures. The national ACCT training package has been updated and is now modular based, enabling staff groups to be trained in areas of the ACCT process that are most relevant to their role, with the remaining modules followed up at a later stage in order to provide staff with further insight into supporting prisoners in crisis.	April 2017 Head of Safer Custody From 1 April 2017 Head of Safer Custody & Head of Business Assurance

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			Bullingdon received the "training for trainers" sessions in February 2017, and will be delivering this training to current staff from 1 April 2017.	From 1 April 2017 Head of Safer Custody
2	The Head of Healthcare should ensure that: • mental health services meet the needs of prisoners at Bullingdon , with a referral system that results in a timely, face to face assessments using all relevant information for appropriate continuity of care and follow-up, and that prisoners have access to services equivalent to those in the community; • transferred prisoners attend a prompt medication review with a GP so that there are no unnecessary breaks in treatment and to assess the prisoner's mental state when their medication has changed; • there is appropriate follow-up by the healthcare when a prisoner misses their medication.	Accepted	It is accepted that all referred prisoners should receive a face to face consultation at an assessment either by primary care services such as nurses, paramedics or the GP's, depending on the information provided with the referral. The healthcare provider will work with the healthcare commissioners who have committed to review the provision of mental health services at HMP Bullingdon, in particular for patients with a personality disorder. The healthcare provider is developing a process to ensure that all transferred prisoners continue to receive their prescribed medication using the prescription details available on SystmOne (the electronic patient record). Repeat prescriptions are available from both GPs and non-medical prescribers, including members of the pharmacy team. All prescribers are suitably qualified to assess both the medications a person is taking and any changes in clinical presentation (which would include mental health). It is accepted that where prisoners miss their medication, this should be followed up to understand the reasons for not attending and ensure that prisoners understand the consequences of missing medication. The healthcare provider will focus on medications listed in the NICE Guidance (NG57), which details those medicines which, if missed may have a	August 2017 Head of Healthcare and NHS England June 2017 Head of Healthcare June 2017 Head of Healthcare

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			detrimental effect on people's health as a starting point and then review later in the year. The South Staffordshire and Shropshire NHS Foundation Trust (SSSFT), who provide "In-reach" secondary mental health services and an Inclusion service (substance misuse psychosocial interventions), have a robust framework of audit and governance processes to ensure that referrals are managed and prioritised to ensure equivalence of service and continuity of care. The SSSFT contribute to the follow up of prisoners where mental health medication has been missed, and inclusion staff ensure the healthcare team are made aware of any occasion when a prisoner identifies that they have missed mental health medication.	Ongoing. SSSFT