

# Action Plan in response to the PPO Report into the death of Mr John Brundle on 22/01/2021 at HMP Elmley

| Rec No | Recommendation   | Accepted / Not accepted | Response Action Taken / Planned  | Responsible Owner and Organisation   | Target Date  |
|--------|--|-------------------------|--|--|--------------|
| 1      | The Governor and Head of Healthcare should ensure that prison and healthcare staff understand that they should consider a prisoner's risk factors for suicide and self-harm when assessing risk and should not rely solely on what the prisoner says about his intentions or how he presents | Accepted                | <p>In order to reinforce the importance of assessing all risks and triggers and not relying solely on an individual's presentation, ACCT learning circles have been arranged for staff working in reception, the first night centre, and healthcare initially. Learning from these sessions will be rolled out across the prison to all staff, including stakeholders.</p> <p>Healthcare staff have been reminded of the importance of using search buttons within SystemOne to search for key risk factors including mental health and substance misuse so that they do not rely solely on information from the prisoner. Risk information is shared via the shared cell risk assessment and by the opening of an ACCT if required.</p> | <p>Head of Safer Custody<br/>HMPPS</p> <p>Head of Healthcare<br/>Integrated Care 24 (IC24)</p> | January 2022 |
| 2      | The Governor should ensure that staff:   | Accepted                | Staff briefings and weekly notices will be used to raise awareness of the importance of staff having   | Head of Safer Custody and  | January 2022 |



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|   | <ul style="list-style-type: none"> <li>•have regular meaningful interaction with the prisoners in their care; and</li> <li>•record important interactions and conversations in NOMIS and the wing observation book</li> </ul>                             |          | <p>regular meaningful interaction with prisoners and to document anything important in NOMIS and the wing observation book, as appropriate.</p> <p>The Safer Custody team have introduced a weekly review of observation book entries at which time they will check the NOMIS case notes for any prisoner mentioned to ensure that relevant information has been entered into NOMIS. Feedback will be provided to Custodial Managers (CM) and Senior Officers (SO) through briefings and planned meetings.</p>   | <p>Head of Residential Services</p> <p>HMPPS</p> |              |
| 3 | <p>The Governor should ensure that:</p> <ul style="list-style-type: none"> <li>•cells are always properly equipped and cleaned before prisoners are moved into them; and</li> <li>•a record is kept when a cell is deep cleaned for any reason</li> </ul> | Accepted | <p>The prison will introduce a schedule of quality assurance checks to ensure that cells are properly equipped and cleaned before a prisoner is moved into them. Where any concerns are identified, remedial action will be taken.</p> <p>Cleaning officers will be reminded of the need to ensure that pre-occupancy checks required as part of the decency framework are fully completed to reflect where a deep clean has been undertaken.</p> <p>The weekly notice will be used to convey this process to SOs and a learning circle will be held at the SO daily meeting to check that all officers are aware.</p> | <p>Head of Residential Services</p> <p>HMPPS</p> | January 2022 |



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| 4 | The Head of Healthcare should ensure that prisoners who have a history of self-harm and/or have previously been admitted to a psychiatric hospital are referred for a mental health assessment in reception, in line with NICE guidelines |  | The current practice on SystemOne for first night and reception healthcare checks, identifies the need to refer to the mental health team. A notice will be issued to communicate and remind healthcare staff of this. | Head of Healthcare<br>IC24 | January 2022 |
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