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

Bradleigh Barnes on 28/12/2019 at HMP Portland

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should identify prisoners at HMP Portland whose clinical record is in a name different to the one used by the prison and, together with the SystmOne IT lead, should review the process for flagging such patients to ensure that clinical staff are able to identify their records from either name.	Accepted	SystmOne records are accessed during the reception process and any prisoners identified with different names on the clinical record are flagged to administrative staff, this is then recorded on SystmOne with a red flag so that clinicians are aware when accessing the record. There is a notice board within the main healthcare office to identify those who have a different name on clinical and prison records, as well as those who come in with the same surname as a prisoner already in the establishment. All staff have been made aware that when searching the clinical record they must use the prison number to search and not the surname as this is unique and will not allow for another prisoner's notes to be opened.	Head of Healthcare Practice Plus Group (PPG)	Completed

2	The Head of Mental Health should ensure that all available information is taken into consideration when triaging a prisoner for mental health assessment, in particular: •further information should be obtained from the security department where it is indicated that relevant information has been received; and •relevant applications by the prisoner should be scanned on to their clinical record.	Accepted	Triage and assessment templates have been reviewed locally, regionally and nationally alongside SystmOne templates for crisis management, risk assessment and care planning. The mental health SystmOne hub is going live imminently which will improve the availability of information relating to healthcare. Weekly multi-professional complex case clinic (MPCCC) meetings review clinical risk, concerns and prisoners with higher levels of need and/or risk on a weekly basis. Healthcare attend the weekly safety intervention meetings (SIM) where prisoners with complex needs are discussed. Robust working relationships have been formed with safer custody, security and other key departments to develop better ways of supporting prisoners. Monthly SystmOne audits are now being undertaken with learning documents cascading through clinical lead meetings and one-to-ones, down in to site team meetings for further embedding in supervisions. Best practice has been discussed within the mental health team regarding appropriate information gathering from key sources, especially with reference to those on Care Programme Approach (CPA). To scan individual applications on to each prisoner's clinical record would require admin time that the team cannot currently cover. Due to this,	Head of Healthcare PPG	November 2021

			in order to mitigate risk, a local operating procedure (LOP) will be written and implemented whereby applications are logged onto SystmOne and safely stored, and entries are added to patient SystmOne records with information relating to the request.		
3	The NHS Commissioner should urgently review the mental health service at HMP Portland, with the Governor and Head of Healthcare, and ensure the service specification is met and an effective service is delivered to all prisoners.	Accepted	Excellent communications have been established between the Regional Manager, Head of Healthcare, Regional Mental Health Lead and Commissioning Team with regular contact and additional projects now in place. The Regional Mental Health Lead is reviewing compliance with the mental health specification and developing learning tools and audits to support further work. The Mental Health Clinical Lead and Head of Healthcare have developed key relationships with patient engagement staff, wing officers and departments to enable better communication to prisoners. The Head of Healthcare and Mental Health Clinical Lead have reviewed the process for health and mental health applications, complaints and communication pathways. In addition, the patient engagement lead has held forums with prisoners to gauge their feedback on health services and to enable more opportunities for prisoners to access health promotion advice and information. As a result of this changes have been made to the process so that appointments can be expedited and waiting times reduced.	Head of Healthcare PPG	Completed

4	The Governor and the Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide and self-harm in line with national guidelines including: •assessments and first case reviews should take place within 24 hours of the start of ACCT monitoring; •assessments and case reviews should be separate; •a member of the healthcare team must attend the first case review; •all staff visiting the wing should be made aware if the prisoner they are seeing is subject to ACCT monitoring; •caremap actions should be specific and meaningful and aimed at reducing the prisoners' risks to themselves; and •ACCT documents should be completed fully and accurately, including following the prescribed level of observations at irregular intervals and recording them.	Accepted	A new version of ACCT (ACCT v6) was rolled out nationally in July 2021 and updated Suicide and Self-harm training providing guidance on the effective management of the ACCT process is being delivered to all staff. All appropriate and meaningful actions are now recorded on the Immediate Action Plan and on the Support Actions Form in ACCT v6, and there are now additional prompts for case coordinators to ensure these are reviewed and marked as completed when appropriate. A member of healthcare staff is now always present at the first review and this is monitored for compliance. If the review must take place out of hours without healthcare then an interim review is carried out and a full multidisciplinary review is completed with healthcare present the next day. All healthcare staff have been made aware of the expectations and targets regarding ACCT reviews and recent compliance has hit 100% due to collaborative working with safer custody on an ACCT rota. Healthcare attendance at ACCT reviews is now included in local and regional mental health data performance monitoring. A notice to staff (NTS) was published in May 2021 to ensure that all staff visiting the wing are informed if the prisoner they are seeing is subject to ACCT monitoring so that their interaction / meeting can be recorded in the ACCT document. In May 2021 ACCT case managers were reminded via email that the initial ACCT	Head of Healthcare PPG Head of Safer Custody HMPPS	Completed

			assessment must take place within 24 hours and that this must be separate to the first case review. Compliance checks are in place to ensure that this is happening and also that ACCT documents are completed accurately with observations recorded clearly at irregular intervals.		
5	The Governor should ensure that the decision to move a prisoner from a safer cell to a standard cell is taken at an ACCT review.	Accepted	All decisions to move prisoners from safer cells to standard cells are reviewed, discussed and documented as part of a multidisciplinary ACCT review process. A NTS was issued in May 2021 outlining this requirement and all custodial managers and supervising officers have been reminded of the correct procedure.	Head of Safer Custody HMPPS	Completed
6	The Head of Healthcare should ensure that all healthcare staff understand their responsibilities during and after a use of force, as set out in PSO 1600.	Accepted	Healthcare staff will have training in the completion of F213 forms and sign to say they understand their responsibilities under PSO 1600. This is to be included as part of the induction for new staff and will be raised at the local quality delivery board, to be included in the breakaway training.	Head of Healthcare PPG	November 2021
7	The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.		The report has been shared with the named member of staff and she has had training around documentation of medical records. Clinical supervision has been delivered and continues to be available for staff. Record Keeping features on the Practice Plus Group (PPG) annual audit schedule and is audited using this tool with results then reviewed through local quality assurance meetings.	Head of Healthcare PPG	Completed
8	The Governor and Head of Healthcare should ensure that staff are aware that		A NTS was issued to all staff in May 2021 containing guidance on resuscitation and	Head of safer Custody	Completed

	ligatures should be removed before resuscitation is attempted.		reminding staff that prior to attempting resuscitation any ligatures should be removed.	HMPPS	
9	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.		A NTS was issued in May 2021 containing guidance on resuscitation, which includes the circumstances on when it is not appropriate.	Head of Safer Custody HMPPS	Completed
10	The Governor should ensure that the prison's designated liaison officer cooperates fully with all requests from the PPO for information, material or access to establishments and prisoners in line with PSI 58/2010.		There is now a designated liaison officer who will be the main point of contact following a death in custody and will ensure that all requests for information and documentation are acknowledged and actioned promptly.	Head of safer Custody HMPPS	Completed