



**Action Plan – Mr Matthew Pearson at HMP Ranby – Self-Inflicted death on 08/01/2020**

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
	<p>healthcare staff where relevant.</p> <ul style="list-style-type: none"> <li>• Case reviews consider all relevant information that affects risk, address all issues through specific and meaningful caremap actions, and observations are only reduced when there has been a clear reduction in risk.</li> <li>• Conversations are carried out as directed and documented in the ongoing record.</li> <li>• All staff in contact with prisoners are trained in ACCT procedures and understand that they should record all relevant information about risk in the ongoing record.</li> </ul>		<p>2020 those staff highlighted within the report in relation to the quality of ACCT case management also completed the nationally mandated ACCT case manager refresher training. This reiterates the need for reviews to be multidisciplinary and reminds staff that consideration should be given to all relevant risk information so that caremap actions can be tailored to the individual's needs. In addition, it makes clear that observations must not be reduced before there has been a reduction in risk and that conversations should be documented. This will continue to be delivered as part of the establishment's training programme once this resumes.</p> <p>To ensure a multidisciplinary approach the Safety team emails the Mental Health team a copy of the daily briefing sheet to ensure that they are aware of any initial ACCT reviews taking place. For subsequent reviews the process for input into ACCT reviews where healthcare staff are unable to attend in person has been reviewed. Any ACCT review information is now shared in writing with the case manager via email and this is recorded on the patient's SystemOne record. Compliance is checked through regular record keeping audits conducted by the Mental Health matron.</p> <p>The Head of Healthcare has also directed the matrons for Primary Care, Mental Health and Substance Misuse pathways to ensure all new staff have SASH training during their induction period. This will include all new agency staff. Staff will be reminded that all relevant information and conversations must also be documented within the ACCT paperwork to ensure risk information is shared appropriately.</p>	

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			<p>In order to monitor the effectiveness of these measures and that all interactions are of a good quality and have been fully recorded, managers within the Safety team complete a snapshot review of ACCT documents and feedback their findings, recommendations and any actions for improvement through the monthly Safer Custody meeting structure.</p> <p>A robust three tier management check system is also in place to ensure that all ACCT documents are checked within 72 hours of opening, on a weekly basis while open and following closure. This provides assurance that the required standards in relation to multidisciplinary attendance, defensible decision making in relation to observations and consideration of relevant risk information when setting caremaps actions are being met.</p>	
3	The Head of Healthcare should ensure that the mental health service has the capacity to provide appropriate care to prisoners judged to be at risk of suicide and self-harm.	Accepted	<p>A robust recruitment programme is underway to ensure the Mental Health team is running at the required capacity and that vacant posts within the team are filled as a priority.</p> <p>The Head of Healthcare has also agreed the procurement of extra agency nurses to ensure the service meets the needs of prisoners during the recruitment process.</p> <p>The Offender Health Directorate has instructed the Area Clinical Nurse Specialist to provide support to the Mental Health team to ensure staff are confident and skilled in the management of suicide and self-harm.</p>	Head of Healthcare Completed
4	The Head of Healthcare should ensure that nurses safely issue	Accepted	The healthcare and prison teams work closely together when supervising the medication dispensing areas in order to identify those who are known to be	Head of Healthcare/

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	<p>medication to prisoners who do not keep and administer their own medication, and that reasonable checks are undertaken to ensure that the prisoner has taken the medication at the time of collection.</p>		<p>diverting and ensure that prisoners are taking their medication at the time of collection. A programme of regular meetings between Substance Misuse Officers on Houseblock 2 and Substance Misuse Healthcare staff was introduced in February 2020 to improve communication and collaborative working in these two areas so that any non-compliance can be identified more effectively.</p> <p>There is also a system in place whereby staff report all incidents of diversion or concealment and staff have been made aware that this must be documented on the patient record. Patients are then sent a letter warning them that further incidents will result in their medication being reviewed/stopped.</p> <p>Cell checks are targeted at those suspected of diverting and also those who have been prescribed highly tradable medication. Where compliance issues are raised following these cell checks, referrals are made to amend medication risk assessments to be issued with supervision and the prison is informed through the Mercury Intelligence System.</p> <p>Robust Drug Strategy meetings have now been introduced where compliance with and effectiveness of these measures can be assessed by a multi-disciplinary team.</p> <p>These measures will continue to be assessed over the next three months by the Head of Healthcare and Head of Health and Wellbeing to ensure they are effective and embedded with findings fed back to the Drug Strategy meeting.</p>	<p>Head of Health and Wellbeing October 2020</p>

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5	The Governor should inform the Ombudsman of the findings of the internal investigation into the events on the night of 7 to 8 January, and of any action taken as a result, by 30 September 2020.	Accepted	The Deputy Governor will ensure that the report, findings and recommendations from the formal investigation completed by a Senior Manager at HMP Ranby are shared via email with the Prison and Probation Ombudsmen Investigator.	Deputy Governor September 2020
6	The Governor should ensure that staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.	Accepted	The national guidance in relation to staff responsibilities when they find a cell observation panel obscured was sent to all staff via global email by the Safety team in July 2020.  To support staff understanding and adherence to this guidance, Residential Managers will ensure that a further briefing is held on each Houseblock in September 2020.	Head of Safety/Head of Residence September 2020
7	The Governor should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.	Accepted	The national guidance in relation to staff responsibilities to enter a cell as quickly as possible following a dynamic risk assessment where they believe the occupant may be at risk has been shared with all staff via global email by the Safety team in July 2020.  To support staff understanding and adherence to this guidance, Residential Managers will ensure that a further briefing is held on each Houseblock in September 2020.	Head of Safety/Head of Residence September 2020
8	The Governor and Head of Healthcare should ensure that staff are given clear guidance	Accepted	In July 2020, the Safety team re-distributed the guidelines produced by the European Resuscitation Council to all staff at HMP Ranby via email. This makes clear the circumstances in which resuscitation is considered to be	Head of Safety Completed

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	about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.		inappropriate.	
9	The Governor should ensure that a copy of this report is shared with CM A, SO A, SO B, Officer A and Officer B and that a senior manager discusses the Ombudsman's findings with them.	Accepted	A formal meeting will be held by the Deputy Governor with all named staff listed to share the report and discuss the Ombudsman's findings. A written record will be kept of these meetings and shared with respective line managers to ensure that this is included within future supervision or support meetings.	Deputy Governor August 2020
10	The Head of Healthcare should share a copy of this report with Nurse A and Nurse B and share the Ombudsman's findings with them.	Accepted	The Head of Healthcare will meet with Nurse B to share the report and discuss the Ombudsman's findings with her. A written record will be kept of this meeting and shared with Nurse B's direct line manager to ensure that this is included within future supervision or support meetings.  Nurse A no longer works at HMP Ranby.	Head of Healthcare August 2020