

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

Mr Mark Potter on 30.03.2021 at HMP Stocken

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:</p> <ul style="list-style-type: none"> • receive ACCT training, including refresher training; • take into account all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate; and • share important information about a prisoner's risk of suicide and self-harm with prison staff. 	Accepted	<p>The Head of Healthcare and Mental Health Team Lead have reviewed the Practice Plus Group (PPG) policies to ensure they have been implemented and are actively being used and monitored.</p> <p>Risk of suicide and self-harm is assessed at every patient interaction using the updated integrated mental health template hub found on SystemOne.</p> <ul style="list-style-type: none"> • Healthcare staff already have written guidelines in relation to the ACCT process, however it has been requested staff also receive face to face training from the prison via the Safer Custody team. This is currently in progress. • The Practice Plus Group triage template encourages an assessment of risk in line with the NICE (National Institute for Health and Care Excellence) guidelines for self-harm. These guidelines include physical health, mental state, safeguarding concerns, social 	<p>Head of Healthcare</p> <p>PPG</p>	Completed



			<p>circumstances and risks of repetition or suicide. Following the completion of the triage template the mental health practitioner will decide whether ACCT procedures need to commence, or not.</p> <ul style="list-style-type: none"> If staff assess a person as having an increased risk to self they are expected, and have been reminded, to liaise with prison staff, the safer custody team and any other relevant services to share and manage the risks. This is as well as considering using the ACCT process for enhanced support and monitoring. <p>The Head of Safety has reviewed the staff induction to ensure all staff, including healthcare staff, receive ACCT awareness training as part of their induction. In addition ACCT refresher training is being reviewed to ensure it captures all the necessary staff.</p>	<p>Head of Safety & Equalities</p> <p>HMPPS</p>	Completed
2	The Head of Healthcare should share this report with Nurse C and discuss the Ombudsman's findings with him.	Accepted	This report has been shared individually with the nurse and the recommendations will also be shared with the wider healthcare team at their Quality Assurance meeting.	<p>Head of Healthcare</p> <p>PPG</p>	Completed
3	The Governor should ensure that the security team share information about prisoners' risk factors with wing staff.	Accepted	Security information is shared via a daily briefing which is read out and discussed at the morning operational meeting alongside important information of note from the security team. The briefing is also emailed to relevant members of	<p>Head of Security</p> <p>HMPPS</p>	Completed



			<p>staff, including Band 4 and Band 5 residential wing managers, so it can be disseminated to their staff.</p> <p>In August 2021 the security department implemented a daily (Monday to Friday) morning analysis exercise which triages security information received the day before. A security analyst, security collator and security manager review all the intelligence received over the previous 24 hours in order to assess what information needs attention the soonest and who needs to be alerted to the information.</p>		
4	The Governor should ensure that there is a clear process by which families and friends can raise concerns about a prisoner's wellbeing, and that such calls are monitored, recorded and followed up.	Accepted	<p>There is a safer custody hotline available 24/7 which enables prisoners families/friends to call the prison and raise any concerns they have about a prisoner and their wellbeing. It is an automated voicemail service with any messages left being checked several times a day. The line is checked both AM & PM by the safety team, in the evening by the Orderly Officer and twice through the night by the Night Orderly Officer. All messages are noted on a spreadsheet and any action required is recorded with a named member of staff tasked to it.</p> <p>If any unclear messages are left the safety team will endeavour to identify callers and call them back. This will ensure messages are not missed</p>	<p>Head of Safety & Equalities</p> <p>HMPPS</p>	Completed



			<p>and allow appropriate actions to be carried out and recorded.</p> <p>All Orderly Officers and the Safety Team have been briefed on the expectations required when working on the hotline. Also, a monthly quality assurance process is completed by the Safety Custodial Manager (CM). They check the quality of the messages recorded on the spreadsheet and any actions completed as a result of the call to the hotline.</p>	<p>Safety Custodial Manager</p> <p>HMPPS</p>	Completed
5	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.	Accepted	The Governor has re-issued to all staff the learning bulletin created by the Safety Team which provides guidance to support the decision making process for when it is appropriate and not appropriate to perform CPR.	<p>Head of Safety & Equalities</p> <p>HMPPS</p>	Completed
6	The Governor and the Head of Healthcare should ensure that all medical equipment is checked as a matter of urgency and systems put in place for ongoing monitoring.	Accepted	Within the prison there are 10 defibrillators. Healthcare own and are responsible for the 5 defibrillators stored in the healthcare department and across prison wing dispensary hatches. This equipment is checked daily by the attending nursing staff and is also checked weekly by a senior clinical member of staff to ensure the equipment is available and working. This is recorded on a signing sheet to evidence they have been checked.	<p>Head of Healthcare</p> <p>PPG</p>	Completed



			The other 5 defibrillators belong to the prison, which includes the one that failed to work in this case. HMP Stocken have conducted an urgent review of all current prison defibrillators to ensure they are all in working order. Also, a review of the current process for inspecting prison equipment has taken place to ensure there is a system in place for ongoing monitoring. Weekly assurance checks by residential managers have been introduced to monitor the equipment with the check being signed for and noted in the wing diary. Also, the Safety CM has put together an aid memoir to guide wing managers on what must be checked on the defibrillators.	Head of Business Assurance HMPPS	Completed
7	The Head of Healthcare should remind staff of the need to follow up any concerns about an individual's mental health and to refer prisoners to relevant support services.	Accepted	All staff have been reminded of the need to follow up any concerns about an individual's mental health and to refer them to relevant support services. It will be discussed with staff during daily multidisciplinary team meetings quality assurance meetings, staff one to ones and supervision.	Head of Healthcare PPG	Completed
8	The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.	Accepted	This report has been shared and discussed with the named staff, and the recommendations will also be shared with the wider healthcare team at their Quality Assurance meeting.	Head of Healthcare PPG	Completed
9	The Head of Healthcare should ensure that: <ul style="list-style-type: none"> record keeping is regularly audited, and that staff are 	Accepted	In keeping with the Health and Justice Practice Plus Group guidelines record keeping is now audited on a monthly bases. This was introduced in October 2021 and is required to be added to a	Head of Healthcare PPG	Completed



	<p>reminded about the need for quality entries in the SystemOne medical records;</p> <ul style="list-style-type: none"> • immediately review the operational procedures of the mental health team, including putting in place clear decision-making protocols for staff roles, case allocation and timings; and immediately implement a system to ensure that prisoners on the mental healthcare patient list continue to be monitored despite staff absences. 		<p>database and submitted for checking. The requirements of quality record keeping will be raised with staff during quality assurance meetings, daily MDT meetings and supervision sessions. Any recommendations arising from serious incidents are also discussed with individuals and in team meetings.</p> <p>Changes have already been introduced to operational procedures in the Mental Health team following the appointment of a new Mental Health team lead in July 2021. Referral wait times have been significantly improved with the target times now being met and monitored via monthly Health in Justice indicators of performance and quality reports. All caseloads have been reviewed and allocated appropriately with each patient having a named worker. The weekly mental health team meeting reviews all patients who have been triaged to discuss decision making and case allocation. Caseload management is also discussed at the meeting and this includes the management of absent staff caseloads. A further period of monitoring is required for embedding.</p>		
10	The Head of Healthcare should share this report with Nurse B and discuss the Ombudsman's findings with him.	Accepted	This report has been shared and discussed with the named staff, and the recommendations will also be shared with the wider healthcare team at their Quality Assurance meeting.	Head of Healthcare PPG	Completed



11	The relevant NHS Commissioner should review the adequacy of mental health services at Stocken.	Accepted	<p>A formal letter has been sent to the healthcare provider raising the concern of ongoing inadequate staffing of mental health service. Subsequent joint meeting held with provider, NHSE/I Nursing Governance and quality team. Provider requested to provide an action plan around recruitment and retention.</p> <p>The action plan has been reviewed, some success in recruitment of mental health staff although not yet fully recruited (as of October 2021).</p> <p>Ongoing monitoring of staffing, remains as an agenda item on both contract review meetings and Local Delivery board meetings.</p>	<p>Health and Justice Team East Midlands</p> <p>NHSE/I</p>	Completed
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