

Action Plan in response to the PPO Report into the death of Mr Stephen O'Rourke on 16/12/2020 at HMP Wandsworth

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor and the Head of Healthcare should ensure that, when a prisoner transfers to Wandsworth from another prison's healthcare unit:</p> <ul style="list-style-type: none"> • clinicians at Wandsworth speak directly to clinicians at the sending prison to establish the prisoner's care needs; and • information is shared with other relevant staff at Wandsworth 	Accepted	<p>When a known transfer from another prison's healthcare unit is taking place the lead clinician will inform the incoming healthcare team and provide details of level of care and contact numbers. If a prisoner is received without prior notice, the lead clinician will contact the previous healthcare unit for details of level of care and contact numbers. This is now included in the inpatients unit policy.</p>	<p>Head of Healthcare</p> <p>Oxleas NHS Trust</p>	Completed
2	<p>The Governor should ensure that prison staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> • a case manager is appointed at the first case review, who should lead all subsequent case reviews, wherever possible; • staff are aware of the potential risk factors and triggers that might 	Accepted	<p>A new version of ACCT (ACCT v6) was rolled out nationally in July 2021. All newly opened ACCTs are now discussed as part of the daily briefings to ensure that the required assessment and first case reviews are completed within the mandated timeframes and have in-reach / mental health participation as required.</p> <p>The establishment has embedded the national ACCT quality assurance process which is</p>	<p>Head of Safety</p> <p>HMPPS</p>	Completed



	<p>increase a prisoner's risk, including conviction;</p> <ul style="list-style-type: none"> • a multidisciplinary review is held when there is evidence of a significant change in risk; and • staff adhere to the frequency of observations as specified in the ACCT document and record those observations contemporaneously. 		<p>monitored daily with learning being shared as part of the daily briefing. The quality assurance checks capture all aspects of the ACCT document including the frequency and compliance of observations, and whether there is multi-disciplinary attendance at reviews. Any identified issues are recorded, and appropriate follow up action taken.</p> <p>In line with ACCT v6 guidance, a case coordinator is appointed at the first case review and they, will lead each case review, wherever possible, to ensure consistency. Prisoners deemed to be complex cases are allocated a specific case coordinator and will be managed by a governor grade, where necessary.</p> <p>Every governor grade, Custodial Manager (CM) and Senior Officer (SO) has received risks and triggers training, so there should be a SO present on reception who has had this training.</p> <p>All known risks are recorded at the front of the ACCT document so that they are easily visible and the senior management team now share alerts about prisoners attending court each day if there is a known risk relating to sentencing to ensure that appropriate follow up support is provided when a prisoner returns form court.</p>		
3	The Governor should commission an investigation into the actions of	Accepted	An immediate fact-finding investigation and an early learning review was completed following Mr	Head of Safety	Completed



	SO A, SO D, CM A, CM B, SO B and SO C in relation to the failure to hold an ACCT review when Mr O'Rourke returned from court on 15 December, with a view to considering whether disciplinary action is appropriate.		O'Rourke's death. A decision was taken not to commission a further investigation into the actions of staff as learning from this incident highlighted areas for improving communication and oversight of ACCT case reviews which will prevent future case reviews from being missed.	HMPPS	
4	The Head of Healthcare should ensure that: <ul style="list-style-type: none"> • medical records clearly indicate when a prisoner is subject to ACCT monitoring; and • healthcare staff should record information from ACCT reviews in a prisoner's medical record. • there is a clear protocol for discharging a prisoner from the mental health team to the primary care team for ongoing mental health support. 	Accepted	<p>Medical records are updated daily to reflect if a prisoner is subject to ACCT monitoring. This is noted on SystmOne records as a current issue and following the closure of the ACCT it will show as a past issue.</p> <p>Healthcare are implementing a template for SystmOne medical records to record ACCT reviews and this will include the level of observations and management plans.</p> <p>Discharges from the mental health team to the primary care team will be included in the mental health operating policy. Referrals will be made via task or to the primary care complex case meetings.</p>	Head of Healthcare Oxleas NHS Trust	June 2022
5	The Governor should contact the Ombudsman to arrange a meeting to discuss recent self-inflicted deaths at Wandsworth.	Accepted	The Governor has made initial contact with the Ombudsman to arrange a meeting.	Governor HMPPS	Completed

