

Action Plan in response to the PPO Report into the death of Mr Damien Price on 02/12/2021 at HMP Swaleside

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national instructions, including that:</p> <ul style="list-style-type: none"> • Staff consider all current and future risk factors and triggers when they consider stopping ACCT monitoring procedures; <p>and</p> <ul style="list-style-type: none"> • Care plans are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped. 	Accepted	<p>As of July 2022 all staff have received additional support on using the ACCT case management process. HMP Swaleside has worked collaboratively with the regional group safety team and psychology department to ensure staff understand they must consider all risks, triggers and protective factors when using ACCT monitoring procedures at all times, including when staff are considering stopping monitoring.</p> <p>The additional training also highlighted the importance of effective risk identification and adopting a person-centred approach to ACCT to ensure the appropriate support and interventions are in place. Staff were reminded that ACCT Care Plans should include actions that are specific, meaningful and individualised to reduce or mitigate risk of harm, and that support actions are complete before an ACCT is closed.</p>	Head of Safety (HMPPS)	Completed



2	<p>The Governor, Head of Healthcare and Head of Pharmacy should ensure that:</p> <ul style="list-style-type: none"> • When changes are made to the location of medication, it should be communicated to all healthcare staff so that both day and night duty staff are aware; • When prisoners do not collect their medication, a reason for their non-attendance is recorded; and • Procedures are in place to ensure that prisoners, who are unable to collect their medication through no fault of their own, are given it, including at their cell door, if necessary. 	Accepted	<p>Local processes have been introduced to ensure that all healthcare staff are aware of any changes to the dispensing of medication. In the event that a prisoner does not collect their medication, all staff are now required to clearly document the reasons for this.</p> <p>In line with the medicines management professional regulations, and depending on the type of medication being administered, healthcare staff will ensure prisoners who are unable to collect their medication through no fault of their own will be given it. This may include, but is not limited to, administering it at their cell door.</p>	Head of Healthcare (NHS England)	Completed
3	<p>NHS England should ensure that when HMP Swaleside's contract for health services is next renewed the healthcare provider is contracted to provide additional staffing levels to ensure that medication hatches and treatment rooms on A Wing and D Wing are staffed by healthcare professionals in line with current</p>	Accepted	<p>NHS England, alongside the Governor of HMP Swaleside and Oxleas are working together to ensure that there will be suitable medication rooms that meet clinical and control standards on both A and D wing.</p> <p>Once this work is completed, the areas will be staffed by healthcare professionals in line with current practice on the other wings within the prison.</p>	Senior commissioning manager (NHS England), Head of Healthcare Oxleas)	June 2023



	practice on the other of Swaleside's wings.				
4	The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.	Accepted	The Governor and Head of Healthcare have worked with regional groups and the group safety team to ensure all staff receive further support through upskilling. These sessions focus on the importance of ensuring staff review all available risk information when assessing a prisoner's risk of suicide and self-harm and that an ACCT is opened when appropriate.	Head of Safety (HMPPS)	Completed and Ongoing.
5	The Governor should ensure that: <ul style="list-style-type: none"> • Staff identify information about bullying, in all its forms, and fully and promptly investigate it, where necessary; • Alleged perpetrators are appropriately challenged; and victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed. 	Accepted	<p>A safety briefing has been delivered to staff about the importance of identifying victims and perpetrators of bullying. The briefing reminded staff to ensure that when bullying is identified, they must promptly report this through the appropriate means and use the challenge, support and intervention plan (CSIP) process.</p> <p>HMP Swaleside has continued to provide guidance and raise awareness with staff through refresher sessions including on how to challenge perpetrators, supporting victims and how any involvement in bullying can increase the risk of suicide and self-harm.</p>	Head of Safety (HMPPS)	Completed
6	The Governor should ensure that: <ul style="list-style-type: none"> • A local protocol is developed and shared with staff to instruct 	Accepted	A local policy has been developed and shared with staff informing them of their responsibilities when they find a cell observation panel obscured.	Head of Residence (HMPPS)	Completed



	<p>them on what to do if they find a cell observation panel obscured at any time of day; and</p> <ul style="list-style-type: none"> • Subject to a risk assessment and in line with PSI 64/2011, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk. 		<p>Separately, staff have been reminded through a Notice to Staff that, subject to a rapid dynamic risk assessment of the situation, staff have a duty to enter a cell without delay if there appears to be an immediate danger to life.</p>		
7	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> • Officers understand the importance of communicating the details of a medical emergency as quickly as possible; • Control room staff call an ambulance as soon as they receive a medical emergency code; and • There are no delays in ambulances being given access to the prison. 	Accepted	<p>Medical emergency response information cards explaining when to use medical emergency response codes have been issued to all HMP Swaleside staff. The pocket cards remind staff that the appropriate medical emergency response code should be called immediately.</p> <p>Additionally, a safety briefing was delivered by the Head of Operations to all staff reminding them of the actions they must take in a medical emergency. The briefing detailed the steps staff should follow once the code has been called, including the calling of an ambulance, and the importance of doing so promptly.</p> <p>Gate staff have been reminded that ambulances must be prioritised and allowed access to the establishment as quickly as possible.</p>	Head of Safety (HMPPS)	Completed



8	The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.	Accepted	The Governor and Head of Healthcare have shared a copy of the report with all members of staff named within the report.	Head of Safety (HMPPS) Head of Healthcare (Oxleas)	Completed
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