

Action Plan in response to the PPO Report into the death of Mr David Morgan on the 30/08/2018 at HMP Chelmsford

| Rec No | Recommendation | Accepted / Not accepted | Response Action Taken / Planned | Responsible Owner and Organisation | Target Date |
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| 1 | The Prison Group Director and the NHS England Regional Director responsible for commissioning healthcare services at Chelmsford should each write to the Ombudsman setting out what action they have taken in response to this report. | Accepted | <p>The Prison Group Director for the Herts, Essex and Suffolk Prison Group has written to the PPO to set out the actions taken and the improvements that have been made following this report being issued.</p> <p>The NHS England Regional Director has also written to the PPO to set out the actions taken including information on the review of the culture within the healthcare team and service in January 2021.</p> | <p>Prison Group Director HMPPS</p> <p>Regional Head of Health and Justice NHS England and NHS Improvement (NHS&I)</p> | Completed |
| 2 | The Governor should investigate whether any of the staff present in reception on 22 August, who witnessed Mr Morgan in the holding cell and who are still employed at Chelmsford, should face disciplinary charges. | Accepted | An investigation was commissioned by the Prison Group Director in 2021 and was conducted by an independent Senior Operational Governor. This has now concluded. | Prison Group Director HMPPS | Completed |
| 3 | The Governor should arrange for this report to be shared with Officer and Officer (now CM) by the Governors of their current prisons. | Accepted | The Governors at HMP Stoke Heath and HMP Foston Hall have shared this report with the named members of staff. | Governors at HMP Stoke Heath and HMP Foston Hall HMPPS | Completed |

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| 4 | <p>The Prison Group Director and Governor should review the culture among prison officers and managers. In particular they should put measures in place to ensure that staff treat the prisoners in their care with dignity and respect, and to foster a culture in which staff at all grades feel able to raise concerns if they feel something is not right.</p> | Accepted | <p>In March 2021 the national safety team, psychology services, and the Prison Performance Support Programme (PPSP) team initiated a culture review. This explored both the staff culture and the care and management of prisoners using a number of different tools, including interviews and focus groups.</p> <p>The review was completed in September 2021 and highlighted a number of concerns with a number of recommendations made. Steps were taken to formulate and implement the improvement plan which places safety and decency as a priority and the outcome of the culture review has fed into the local strategic vision, objectives and staff training needs.</p> <p>A Procedural Justice workshop for the local senior management team has also taken place, to support a culture of respect, in which decision making is transparent, unbiased, and principled.</p> | Governor HMPPS | Completed |
| 5 | <p>The Governor should apologise personally to Mr Morgan's next of kin for the failure of her staff to exercise their duty of care to him while he was in their custody.</p> | Accepted | <p>Following the completion of the inquest, the Governor apologised to Mr Morgan's next of kin and wrote a letter to offer condolences and to respond to the findings of the inquest.</p> | Governor HMPPS | Completed |
| 6 | <p>The Governor should ensure that all the officers present during the events of 22 August and still in post receive ACCT refresher training as a matter of urgency.</p> | Accepted | <p>The officers present during the events of 22 August and still in post received ACCT refresher training in 2020.</p> <p>All staff also received ACCT training during 2021 which included training on the updated ACCT version 6 (v6). Refresher training sessions continue to be delivered to raise the confidence and competence of staff dealing with vulnerable and at-risk prisoners.</p> | Governor HMPPS | Completed |



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| 7 | <p>The Head of Healthcare should ensure that policies and procedures are in place to ensure that prescribers and pharmacy work collaboratively to highlight high risk medications, such as baclofen, which are unsuitable for in-possession administration.</p> | Accepted | <p>An audit for high risk medications was introduced in January 2022. Pharmacy led clinics that had been paused due to Covid-19 and discipline staffing levels were also reinstated in June 2022 to facilitate full clinics running.</p> <p>There is an In Possession (IP) policy to which staff have access, and within the policy there is an updated list of high risk medications that are not suitable for IP under any circumstances and all patients are risk assessed before receiving any IP medications.</p> <p>All medications are assessed as high, medium or low risk and this is documented and guidance is available on the next steps for each rating. If no risk level is accessible then staff are aware they must discuss this with the Pharmacy staff before issuing to patients.</p> <p>The IP Policy also states that there should be collaborative working between healthcare departments and joint Pharmacy and GP clinics will both review patients on high risk IP medications.</p> | Head of Healthcare CRG | Completed |
| 8 | <p>The Head of Healthcare should immediately ensure that all healthcare staff are aware of and have access to the National Poisons Information Service, either by telephone or via the online Toxbase service and its use should be mandated in all cases of suspected overdose or poisoning.</p> | Accepted | <p>Guidance on caring for adults and managing acutely intoxicated patients, was shared with all healthcare staff in March 2021.</p> <p>The Head of Healthcare ensured that all healthcare staff are aware of, and have access to, the National Poisons Information Service through Toxbase in April 2021 and this was discussed during regular briefings and as part of staff inductions.</p> | Head of Healthcare CRG | Completed |
| 9 | <p>The Head of Healthcare should ensure that evidence-based tools</p> | Accepted | <p>In January 2021, the Head of Healthcare reviewed the induction package to ensure that it contained the</p> | Head of Healthcare | Completed |



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| | are in place for the immediate recognition of deteriorating health and that this is supported by ongoing competency-based training programme. | | <p>National Early Warning Score (NEWS) which is a mandatory requirement to pass induction.</p> <p>The NEWS chart is also kept in all emergency bags and from July 2021, NEWS1 and NEWS2 are used for recognising deteriorating health.</p> <p>Immediate Life Support (ILS) annual training incorporates the NEWS score training and the use of NEWS forms part of the weekly Primary Care team meetings when discussing incidents or individual patients.</p> | CRG | |
| 10 | The Head of Healthcare should ensure that all cases of suspected poisoning from alcohol and/or drugs are assessed according to National Guidance, such as NEWS2, thereby facilitating standardised assessment and best practice decision-making in regard to ongoing observation, escalation to a senior clinician within the prison or for external specialist advice. | Accepted | <p>NEWS scores are used in conjunction with Toxbase to assess cases of suspected poisoning from alcohol and/or drugs, and NEWS2 provides the means to facilitate a standardised assessment.</p> <p>This score will assist staff to determine whether or not to escalate to senior clinician. A sample of patients are audited for compliance monthly by the Primary Care Lead.</p> | Head of Healthcare CRG | Completed |
| 11 | The Head of Healthcare should immediately ensure that staff comply with NMC regulations on making contemporaneous clinical records and individual accountability for record-keeping. The quality of the medical record should be subject to regular clinical audit against national | Accepted | <p>A record keeping audit is completed monthly to ensure that staff comply with NMC regulations on making contemporaneous clinical records. These audits are then fed into the monthly clinical governance meetings.</p> <p>This is also discussed in staff supervisions where required.</p> | Head of Healthcare CRG | Completed |



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| | documentation standards as part of the clinical audit plan. | | | | |
| 12 | The current healthcare providers and the NHS Regional Director responsible for commissioning healthcare services at Chelmsford, should review the culture and working practices of healthcare managers and staff. In particular they should consider how they perceive their role in the healthcare and safeguarding of the prisoners in their care. | Accepted | <p>The regional commissioning team reviewed the culture and working practices of healthcare managers and staff to ensure that the findings of this review, and also of the clinical review, were addressed and actions were implemented quickly and comprehensively. The results of this and of the staff survey were shared in January 2022.</p> <p>Each department has its own head of function that monitors the ongoing improvements and informs the Head of Healthcare on progress. The Head of Healthcare also monitors that a manager is available at all times to all staff for support.</p> | <p>Head of Healthcare CRG</p> <p>Regional Head of Health and Justice NHS&I</p> | Completed |
| 13 | The Head of Healthcare should ensure that all nurses currently working in Chelmsford are provided with a copy of this report and clinical review and that a reflective discussion, facilitated by a nurse, is arranged in order to ensure that the recommendations arising from this report and the learning implications for the professional conduct of nurses are discussed as a team. | Accepted | <p>The report and clinical review has been shared with all healthcare nurses and was discussed during staff meetings. It was also shared on the RADAR system so that it can be reviewed by all staff when required.</p> <p>The report was also discussed during staff meetings and during the Clinical Governance meeting to ensure the recommendations arising from this report and the learning implications for the professional conduct of nurses are discussed as a team.</p> | Head of Healthcare CRG | Completed |
| 14 | This report should be shared with Essex Partnership University Trust, who were responsible for providing the healthcare services leading up to and at the time of Mr Morgan's death. | Accepted | The report was shared with Essex Partnership University Trust (EPUT) in 2020 by the Regional Head of Health and Justice for NHS England and NHS Improvement NHS England. | Regional Head of Health and Justice NHS&I | Completed |



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| 15 | The Governor should ensure that all calls to the main switchboard that indicate a prisoner might be at risk of harm are taken seriously. The subject of the call and the person who dealt with it should be recorded in the prisoner's NOMIS record and the wing observation book. | Accepted | <p>Switchboard staff have been reminded during staff briefings of the need for urgency when calls are received that indicate a prisoner is at risk of harm and the appropriate response to such calls forms part of their working protocols.</p> <p>Regular communication is sent out to staff on the management of at risk calls and the importance of recording the subject of the call and the person who dealt with it in the prisoner's NOMIS record and the wing observation book. This was also covered within the Safer Custody newsletter.</p> | Governor HMPPS | Completed |
| 16 | The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time. | Accepted | <p>All Custodial Managers received training in April 2021 on the process for emergency escorts and on the assessment of risk to ensure that all risk assessments are completed in accordance with the relevant PSI. This guidance was reissued in December 2021.</p> <p>The risk assessment has also been updated to ensure all Custodial Managers are prompted to consider the use of restraints when the prisoner is being taken to hospital. Additionally, regular bed watch checks ensure that the restraint level is reassessed daily.</p> | Governor HMPPS | Completed |
| 17 | The Governor should ensure that: <ul style="list-style-type: none"> • when a prisoner is in hospital in a critical condition, their next of kin is informed at once; and • Chelmsford's local policy is revised to reflect Prison Rule 22. | Accepted | <p>All staff have been reminded that when a prisoner is in hospital in a critical condition, their next of kin is informed and the policy was shared and discussed during briefings in June 2021.</p> <p>HMP Chelmsford's local policy was reviewed in April 2021 and revised to include Prison Rule 22.</p> | Governor HMPPS | Completed |

