

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

Mr Jack Zarrop on 20/03/2021 at HMP Wormwood Scrubs

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> •staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present; •reception staff consider and record the known risk factors of all newly arrived prisoners; •staff start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; •staff share all information that affects risk; and •staff receive appropriate ACCT training. 	Accepted	<p>ACCT v6 was rolled out in July 2021 and awareness training on how to use ACCT to support prisoners at risk of self-harm and suicide has now been delivered to 97% of operational staff. The training covers how to identify risks and triggers and the importance of considering these along with the prisoner's presentation It also provides guidance on when to open an ACCT, and what should be recorded if the decision is made not to open an ACCT.</p> <p>The first night in custody/reception form, used by reception staff to record known risks and triggers, has been updated based on examples of best practice which were shared nationally. This is now in use at the prison and includes a comprehensive custody care record form which captures key information in order to inform considerations and possible actions for the early days in custody, reception and first night centre. The prisoner induction passport has also been re-designed to</p>	<p>Head of Safety & Early Days Lead</p> <p>HMPPS</p> <p>Head of Healthcare</p> <p>PPG</p>	Completed



			<p>capture all relevant risk information and has been in use since August 2021.</p> <p>Prison managers in the safety team and early days in custody team joined Practise Plus Group (PPG) healthcare managers for a thematic learning meeting on deaths in custody in October 2021. This was led by an NHS nurse consultant and endeavoured to draw together learning from deaths in custody since the pandemic, especially how teams can work together to identify risk and support prisoners in their first days in custody.</p>		
2	The Governor should share this report with SO A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.	Accepted	The Head of Safety has shared a copy of the report and discussed the Ombudsman's findings with named staff.	Head of Safety HMPPS	Completed
3	The Head of Healthcare should share this report with Nurse A, Nurse B, Nurse C and Nurse D and discuss the Ombudsman's findings with them.	Accepted	The Head of Healthcare or designated Healthcare Manager has shared a copy of the report and discussed the Ombudsman's findings with named staff.	Head of Healthcare PPG	Completed
4	The Head of Healthcare should ensure that all healthcare staff make appropriate and timely mental health referrals having reviewed all relevant records available to them.	Accepted	PPG healthcare managers will be attending a thematic learning event on deaths in custody which will include specific work on how and when to make referrals to the mental health service and learning from this event will be disseminated to staff.	Head of Healthcare PPG	January 2022



			A flow chart will be displayed in all treatment rooms on the correct way to make a mental health referral via SystemOne so that staff are clear in the process to be followed.		
5	The Prison Group Director for London should write to the Ombudsman setting out what steps they are taking to address the PPO's concerns in this report and the two previous reports on self-inflicted deaths at Wormwood Scrubs in 2020/21.	Accepted	The Prison Group Director (PGD) for London will write to the Ombudsman outlining the work being done to address these findings.	PGD for London HMPPS	Completed

