

Action Plan – Mr Lee Hellyer at HMP Exeter – AFI on 26/07/2019

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that staff assess risk based on all known risk factors rather than on the prisoner's presentation, and ensure that triggers are appropriately recorded.	Accepted	<p>An early days in custody booklet has been produced to help staff consider the potential risks and triggers for suicide and self-harm above a reliance on a prisoner's presentation. The booklet has been designed based on national guidance and focuses specifically on considering and documenting risk factors. The booklet is used for both new prisoners and those subject to a change of status following a court or video link appearance. All change of status assessments are retained in the prisoner's core record.</p> <p>Reception and first night staff will be trained or re-trained to ensure that all are equipped to recognise the relevant risks that a change of status may present. This will remain under constant review so that all staff working in these areas receive regular refresher training. The Head of Safer Custody will ensure that all staff receive the required training prior to taking on any new post and training records will be retained for assurance purposes.</p> <p>Starting in October 2020, safety related bite sized learning will regularly feature as part of the daily officer briefing to ensure that staff remain focused on the issue of risk awareness.</p> <p>Staff knowledge of risks and triggers is randomly checked by the Safer Custody team as part of the ACCT quality assurance process as well as checking existing ACCT documents to ensure that risks and triggers have been appropriately considered by case managers and that caremap actions have been completed accordingly. Any issues identified are reported back to the Deputy Governor on a monthly basis.</p>	Head of Safer Custody Ongoing

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			Additional assurance is provided by the Group Safety Lead during site support visits.	
2	The Head of Healthcare should ensure that staff fully consider a prisoner's risk of suicide and self-harm, reviewing all available evidence, before approving in-possession medication.	Accepted	<p>Following the initial Practice Plus (formally Care UK) 72hr review which takes place within the healthcare team immediately after a serious incident to identify any immediate learning and associated actions, time was spent with staff in team meetings reviewing the importance of in-possession (IP) risk assessments. Staff were reminded that when completing IP risk assessments to always check for four key words, 'suicide, ACCT, overdose and self-harm' in a prisoner's medical record to ensure they have an accurate picture of history.</p> <p>Training is due to be provided to all staff completing IP risk assessments to ensure consistency. This is also a standard part of the induction process for all new staff within the healthcare team.</p>	Head of Healthcare Completed
3	The Head of Healthcare should ensure that, wherever possible, consultations and assessments with prisoners are carried out privately and, if this cannot happen, the reason is clearly documented.	Accepted	<p>Following the Practice Plus 72 hour review staff were reminded at a team meeting and during handovers that all prisoners who need to be seen in reception should be seen in a consulting room. A further reminder was issued to staff during a team meeting in September 2020 along with a reminder that staff must document when prisoners have refused to engage after being offered a consultation.</p> <p>Record keeping audits take place on a quarterly basis and are reviewed as part of the one to one process between staff and managers. These sessions will be used to monitor the recording of refusals to engage.</p>	Head of Healthcare Completed

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4	The Head of Healthcare should review the process for providing prisoners with mental health support, including providing them with further opportunities to engage if they fail to attend an appointment.	Accepted	<p>As a result of the 72 hour review the mental health team reconsidered the follow up process for failure to attend group sessions, and following the internal learning review carried out by Practice Plus, an action was put into place to follow up all prisoners who do not attend a mental health group session. The reasons for non-attendance are documented and a regular audit is carried out to ascertain why prisoners fail to attend healthcare appointments. The Head of Healthcare shares the outcome of audits with the Governor for ongoing learning.</p> <p>The Head of Healthcare will review the progress of these actions to ensure that they are fully embedded.</p>	Head of Healthcare Completed
5	<p>The Head of Healthcare should ensure that:</p> <ul style="list-style-type: none"> •There is a clear audit trail when prisoners are assessed for in-possession medication; •Staff accurately record all relevant information from their interactions with prisoners, including whether or not a consultation was carried out privately; •Details of appointment letters and times are clearly recorded 	Accepted	<p>There is a clear audit trail when prisoners are assessed for in-possession medication; The audit trail is embedded within SystmOne and therefore system change or improvement is not required. However, future sharing of medical records should make this clear to the clinical reviewer to ensure that they request further information if required.</p> <p>Staff record all relevant information from their interactions with prisoners, including whether or not a consultation was carried out privately and this is reviewed as part of the record keeping audit reviews between staff and managers.</p> <p>Details of appointment letters and times are clearly recorded in prisoners' medical records. The only appointments that sit outside of this process at present are group work sessions for integrated substance misuse services and mental health. The process for this has been reviewed and the same process</p>	Head of Healthcare Ongoing

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	on the prisoner's medical record.		used for primary care appointments will be followed. This will begin when group work sessions are able to commence, they are currently on hold due to the Covid response. The reintroduction of groups will present a good opportunity to in bed a system more aligned with other healthcare appointment processes.	
6	The Governor and Head of Healthcare should ensure staff promptly radio the appropriate code when they discover a medical emergency, so that healthcare staff attend with the relevant equipment and an ambulance is called immediately.	Accepted	<p>The Head of Safer Custody has arranged for all staff to be reissued with pocket guidance on the correct use of emergency codes and radio procedures. Staff are regularly reminded through notices to staff, monthly safety briefings, and through signage displayed in staff areas of the expectation to use emergency codes when a prisoner is found unresponsive. Reminders and quizzes are issued on a bi-monthly basis to ensure that staff remain aware of the emergency codes and the importance of using them.</p> <p>A briefing guide has been provided to control room operators. If they receive a call for medical assistance the operator will query if it is also a code red or blue to prompt the correct emergency response and avoid any delay in an ambulance being requested.</p> <p>Healthcare have briefed staff on what agonal gasp is and the need to call a code blue if a prisoner is found to be breathing abnormally.</p>	Head of Safer Custody November 2020
7	The Governor should ensure that:	Accepted	A family liaison officer (FLO) is appointed immediately following the death of a prisoner and remains in contact with the family up until the inquest. FLO contact records will be retained so that they can be drawn upon in the future if required.	Head of Safer Custody Completed

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	<ul style="list-style-type: none"> •A family liaison officer is appointed as soon as possible after a death in custody; and •Staff are reminded of the guidance in PSI 64/2011 when delivering news of a death to the appointed next of kin, in particular that they are familiar with the details of the death and the prisoner's history. 		<p>The Governing Governor or in command is responsible for allocating an appropriate person to break the news of a death to the allocated next of kin. A copy of PSI 64/2011 <i>Management of prisoners at risk of harm to self, to others and from others</i> has been shared with all members of the senior management team to ensure that when staff are preparing to break the news of a death to the next of kin all relevant details have been considered and staff are equipped with the knowledge to provide a personalised approach.</p> <p>Staff are supported through regular supervision sessions with the regional psychology team.</p>	
8	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> •Arrangements are in place for managing prisoners at risk of suicide and self-harm on D Wing; and • If a prisoner must be removed from D Wing for a period of ACCT monitoring, that they can be returned there once ACCT monitoring stops. 	Accepted	<p>In order to ensure that the ACCT process is not considered detrimental to a prisoner's chance of progression within HMP Exeter, a process has been implemented to deal with those at risk of suicide or self-harm located on D Wing. Immediately following identification of an increased risk of suicide and/or self-harm the individual will be relocated to a main residential unit, this is essential to enable an increased level of observation and additional support mechanisms which are not possible during patrol state on D Wing due to the design of the unit. All entitlements as per the incentives and earned privileges policy are retained by the prisoner wherever they are located.</p> <p>Once the ACCT is closed and past the post closure phase, an individualised risk assessment is completed by a multi-disciplinary team comprising of HMPPS staff and Care UK staff to determine any on-going risk factors.</p>	Head of Safer Custody Completed

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			Following the review the prisoner can return to D wing as soon as it is deemed appropriate.	
9	The Governor should share this report with Officer A, Officer B and SO A and arrange for a senior manager to discuss the Ombudsman's findings with them.	Accepted	The Governor has shared this report with named staff and discussed the findings with them.	Governing Governor/ Head of Safer Custody Completed
10	The Head of Healthcare should share this report with Nurse A, Nurse B and Nurse Cnn and discuss the Ombudsman's findings with them.	Accepted	The Head of Healthcare has shared this report and reviewed the findings with the named staff.	Head of Healthcare Completed