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

Mr Samuel Jones on 01/05/2021 at HMP Portland

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor and Head of Healthcare should ensure that staff: • consider all information when assessing a prisoner's risk of suicide and self-harm; • start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; • record the information considered and their reasoning when they decide not to start ACCT procedures; and • Are reminded of the importance of sharing information that would inform assessment about a prisoner's risk of suicide and self-harm so that all relevant factors are considered when deciding whether to start ACCT procedures.	Accepted	All staff are receiving refresher suicide and self-harm awareness sessions, which covers identifying risks and triggers and the process for starting ACCT monitoring procedures. Additionally, ACCT case coordinators will receive ACCT case coordinator training to ensure that all risks are considered appropriately. If a prisoner is found with a ligature staff will consider opening an ACCT, or whether to increase observations if an ACCT is already open. The consideration for this decision will be documented and discussed at the daily management meetings and the safety intervention meeting (SIM). As part of the ACCT v6 process, ACCT assessors are required to consider all relevant documentation to assist in assessing the appropriate level of risk, reviewing triggers and putting meaningful actions in place to support individuals. This includes sharing information	Head of Safety HMPPS Head of Healthcare and Mental Health Clinical Lead Commissioned Health Provider	January 2023

			which is relevant to identifying and assessing an individual's risks and triggers for self-harm. The SIM supports a joined up approach to supporting individuals on ACCTs as this is a multi-disciplinary meeting attended by safer custody, security, and other key departments including healthcare. This has supported robust working relationships between colleagues across the prison. Triage and assessment templates have been reviewed locally, regionally and nationally alongside SystmOne templates for crisis management, risk assessment and care planning. These templates have been designed to support the completion of high standard crisis plans, care plans and risk assessments. Key ACCT tasks and duties will now be included in supervision meetings with mental health staff, and learning tools specific to ACCT and prisoners in crisis will be included in group supervision and team meeting platforms.		
2	The Head of Healthcare, along with the mental health lead and the lead GP, should review any guidance on the diagnosis and treatment of depression and anxiety at Portland to ensure that it meets NICE standards, to include advice on care planning	Accepted	The GP and acting Head of Healthcare are reviewing NICE guidelines to ensure the diagnosis and treatment of anxiety and depression meet expected guidelines and to put a structured plan in place. Plans are in place via the national psychology lead to implement tier one level group work regarding	Acting Head of Healthcare, GP and Mental Health clinical lead	September 2022

	and use of structured review tools.		anxiety and depression, sleep, and managing emotions via training the mental health support workers and self-help resources. Care planning is a national focus with a new care planning strategy currently being ratified. The successful recruitment of the regional primary care lead for the region will help to drive this at local level and the PROTECT audit will monitor quality via the PPG annual audit schedule.	Commissioned Health Provider	
3	The Head of Healthcare should ensure that prior to discharging a patient from mental health services, there is a multidisciplinary team review which seeks input from all those involved in the person's care, including drug and alcohol services.	Accepted	All referrals and discharges to and from the service are discussed at the weekly mental health multi-disciplinary team (MDT) meeting. Issues of concern and prisoners who are considered higher risk are discussed either at the daily mental health huddle or at the weekly MDT meeting in relation to ongoing and evolving crisis planning. The weekly MDT multi patient complex case conference (MPCCC) meetings review clinical risk, concerns and patients with higher levels of need and/or risk on a weekly basis. Weekly attendance by healthcare at prison SIM is robust and effective working relationships have been formed with safer custody, security and other key departments, and a process has been developed for the sharing of key information. Weekly integrated substance misuse services (ISMS) meetings are undertaken. All patients referred into the pathway are discussed including	Mental health Clinical Lead Commissioned Health Provider	September 2022

			patients with dual diagnosis. Any High risk clients are escalated via MDT / SIM.		
4	The Head of Healthcare, along with the mental health lead and lead GP, should review whether pharmacy technicians should be able to stop antidepressant medication and if so, the process that should be followed.	Accepted	Pharmacy technicians do not stop any medications. A referral is made back to the GP to review the medication. Primary care nurse, mental health or ISMS, depending on medication, will visit and review the patient and ascertain why they have stopped taking their medication.	Head of Healthcare Commissioned Health Provider	Completed
5	The Head of Healthcare should ensure that learning difficulties are clearly identified and recorded in the prisoner's medical record, including what support and adjustments are necessary, and that they are considered when completing assessments and treatment plans.	Accepted	SystmOne records are accessed in reception. Anyone identified as having a diagnosis of a learning difficulty is entered via a read code into the clinical IT system. All patients identified are seen for a review and an ongoing plan of care is created. An audit review will be undertaken.	Head of Healthcare Commissioned Health Provider	October 2022
6	The Head of Healthcare should audit the current provision of mental health services at Portland and identify any gaps in service that affect the review, care and treatment of patients.	Accepted	NHS England (NHSE) commissioners undertook a mental health quality visit in May 2022 and an action plan was developed, which will be tracked via an extraordinary meeting each month and then via the local quality delivery board going forward.	NHSE Commissioners	Completed