

Action Plan in response to the PPO Report into the death of Mr Thomas Brotherton on 22 September 2021 at HMP Preston

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor should remind staff of the importance of:</p> <ul style="list-style-type: none"> • considering all of a prisoner's current risk factors when assessing risk and that they should not rely solely on what a prisoner says, how they present or their past behaviour in the establishment; • where potential risk has been highlighted and a decision is taken to not open an ACCT, they should record their reasons for not doing so; • recording potential triggers for suicide and self-harm to help inform future decisions. 	Accepted	<p>A notice to staff was published in July 2023 reminding staff that when assessing a prisoner's current risk factors in relation to self-harm and suicide, they must take into account all available information from relevant paper and electronic sources including the digital PER, SASH form, Probation and OMU information. In addition, the member of staff must talk to the prisoner and consider their previous and current presentation, although they must not rely solely on this information when making decisions about risk.</p> <p>The notice also reminded staff of the importance of documenting the reasons for the decision not to open an ACCT and that an entry on NOMIS case notes must be made. This must make clear the nature of the potential risk and why a decision not to open an ACCT has been made.</p> <p>Staff will also be reminded to consider potential triggers for suicide and self-harm and, if appropriate, open an ACCT. If a decision is made to open an ACCT, information in relation to risks, triggers and protective factors must be entered in the appropriate section. If a decision is made not to open an ACCT, this must be noted on NOMIS and</p>	Head of Safer Prisons and Equalities HMPPS	Completed



			details about potential triggers and protective factors should be recorded.		
2	The Head of Healthcare should ensure there is a process in place in the event prisoner requests to have a fellow prisoner/third party in attendance at a counselling session, to ensure that the care needs of the prisoner are taken into account.	Accepted	Chaperone posters are in place in Healthcare. A discussion with the mental health service lead took place in March 2023 to ensure that any request for third party attendance is discussed and assessed in line with these recommendations and discussed as part of individualised care plan. Advocacy focus is available and utilised where appropriate.	Head of Healthcare Spectrum Community Health CIC	Completed
3	The Head of Healthcare should ensure that, where the Mental Health Team is aware of an Independent Psychiatric Reports, they request sight of and consider the contents of them as appropriate.	Accepted	<p>The service lead from Tees Esk and Wyre Valley Mental Health Team ensures that if there is information received from the patient or from a Psychiatrist that would suggest the existence of a potential unmet care need, then the mental health team should refer this information to the Psychiatrist to actively seek further information to clarify and action the patient's needs.</p> <p>Once information is received then the mental health caseworker will send an email to solicitor and the Psychiatrist to send a copy of the patients report.</p> <p>Once received, the document will be scanned in and if required a conversation with the visiting Psychiatrist will take place. If report warrants mental health assessment, if not already completed, then the mental health team should assess appropriately. The Nurse/Professional must ensure this is accurately documented on SystemOne in line with NMC record keeping guidelines.</p>	<p>Head of Mental Health Service Lead Tees, Esk and Wear Valleys NHS Foundation Trust</p> <p>Head of Healthcare Spectrum Community Health CIC</p>	Completed



4	<p>The Head of Healthcare and the Mental Health Team Manager should review the process of follow up from the Mental Health Team and how this is completed and monitored. If further input is not required, clear rationale for this decision should be documented. Failed follow up should also be monitored to ensure it takes place promptly.</p>	Accepted	<p>A shared care pathway is now in place in relation to transition of care in-between tiers, including discharge from the mental health team.</p> <p>The mental health team have admin allocated and will ensure that ledgers are coded correctly for failed to attend appointments to ensure the patient is placed back on the waiting list for follow up appointment.</p>	<p>Head of Mental Health Service Lead Tees, Esk and Wear Valleys NHS Foundation Trust</p> <p>Head of Healthcare Spectrum Community Health CIC</p>	Completed
5	<p>The Head of Healthcare should review waiting times for seeing the GP in relation to reviews of antidepressant medication and ensure that there is a triage system in place to ensure prisoners requiring a review of mental health medication are seen within recommended time scales.</p>	Accepted	<p>Reviews are managed by the GP, training to be sourced to train a further clinician to ensure two weeks reviews are being met.</p> <p>An audit of waiting list to be established. New mental health primary care nurse to hold reviews as part of her workplan.</p>	Head of Healthcare Spectrum Community Health CIC	August 2023

