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

Mr Abdullah Popalzai on 29/11/2019 at HMP Pentonville

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 all staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that staff: •do not rely solely on what a prisoner says or how he presents when assessing a prisoner's risk of suicide or self-harm; •consider whether a prisoner has any risk factors or triggers for suicide and self-harm as set out in PSI 64/2011; •read and use all available information (such as person escort records and medical records); • start ACCT procedures where appropriate;	Accepted	A new version of ACCT (version 6) was rolled out nationally in July 2021 and the national ACCT quality assurance processes are now embedded at the prison. ACCTs are monitored daily and updates are given each day at the morning briefing. Prisoners who are involved in higher levels of self-harm or are of raised concern are referred to the Safety Intervention Meeting (SIM) where enhanced case management is discussed and agreed as part of a multi-disciplinary approach. Risks and triggers awareness sessions relating to ACCT are being delivered throughout 2022, with training being delivered first to Senior Officers, ACCT Case Coordinators, and those working in identified higher risk areas such as	Head of Safety HMPPS Head of Healthcare PPG Mental Health Lead BEHMHT	July 2022

	• record the information considered and the reasons for the decision; and • consider use of the enhanced case management approach for prisoners with complex needs.		reception and first night. Awareness sessions will include reminders to not focus solely on a prisoner's presentation but to consider all risks. A notice to staff (NTS) is due to be issued to all staff reminding them that they must review all available information such as the PER when a prisoner arrives into custody. This will be followed up with staff briefings to ensure that all staff have been made aware. Instructions have been issued to advise staff that when a decision is made not to open an ACCT for an individual with identified risk factors, a record of the decision-making process will be recorded. The mental health team contact community GP practices and community mental health teams to obtain patient medical records as standard practice for every new referral. SystmOne has been updated to improve continuity of information between external services; the tabbed journal now shows information from organisations such as liaison & diversion services, police stations and community teams. The medical lead has shared this update with all prescribers and		

			will ensure that this information is shared with all clinical staff, including reception nurses.		
2	The Prison Group Director for London should arrange to meet the Ombudsman, within one month of the date of this report, to discuss what action is being taken to improve the quality of ACCT assessments and reviews at Pentonville.	Accepted	The Prison Group Director for London has made contact with the Ombudsman and a meeting has been arranged.	Prison Group Director for London	Completed
3	The Governor and Head of Healthcare should ensure that: • if a prisoner is not fluent in English, interpretation services are used for first night healthcare screening, initial and regular assessments and ward rounds to provide effective nursing care planning and support; and • all operational and healthcare staff understand how to book interpretation services.	Accepted	A NTS will be published to remind staff of the importance of utilising interpretation services for prisoners who have limited English language skills. The notice will set out how to access and use the service, and assurance checks will now be carried out on the use of interpretation services at the equalities meeting. The Head of Healthcare has ensured that there are posters outlining the process for contacting interpretation services in key areas around the prison, including in reception, the treatment room on C and D wing, and F wing. Interpreters can be booked in advance for routine clinics.	Equalities Lead HMPPS Head of Healthcare PPG	June 2022
4	The Governor and Head of Healthcare should:	Accepted	At the end of each day a Nomis case note is completed for each prisoner located in	Healthcare Governor	July 2022

	• provide guidance to staff on how to safeguard prisoners deemed too volatile to be unlocked from their cells; • ensure that prisoners in the inpatient unit who are unable to leave their cells are offered materials to occupy themselves and that the offer is noted in their medical records; and • remind all senior clinicians to raise their concerns directly with the Mental Health Lead and Governor if prisoners are not able to access the wing regime or in cell activities due to staffing levels.		the inpatient unit containing an overview of any concerns, current behaviour, regime participation and any other relevant information. The Healthcare Governor is currently reviewing the process for how prisoners who are deemed too volatile to be unlocked are risk assessed. Following this review there will be clearer guidance for staff on how to safeguard such prisoners. Barnet, Enfield and Harringay Mental Health Trust (BEHMHT) have an extensive suite of distraction packs available for prisoners. This material has been reviewed and refreshed since this incident. Since January 2022, the Mental Health Unit Lead has been maintaining a diary on the unit, which is used to document any access or enablement issues due to prison staffing levels. This will be escalated to the prison in the monthly Local Delivery Board meetings so that a joint approach can be taken to improve the service provided to prisoners. Datix training will be provided to healthcare staff working in the healthcare	HMPPS Patient Safety & Clinical Quality Lead, PPG Mental Health Unit Lead, BEHMHT	

			unit by the Patient Safety & Clinical Quality Lead to ensure all staff are aware of the internal processes for reporting incidents. Trends identified on Datix will be discussed at the patient safety and clinical quality meetings, which are attended by healthcare managers, the HMPPS Safety Lead for London and the HMPPS Health & Wellbeing Lead.		
5	The Governor should ensure that staffing levels in the inpatient unit are sufficient to offer all prisoners on the unit a full regime.	Accepted	Staffing levels are reviewed daily at the Governor's morning briefing and regime delivery is agreed in line with the local regime management plan. A review of the current multi-unlock policy is underway to ensure that there is a clear process to support defensible decision making and this policy will tie in with the review into the risk assessment process for prisoners who are deemed too volatile to be unlocked.	Head of Safety HMPPS	July 2022
6	The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that staff radio an appropriate emergency code.	Accepted	Staff responsibilities during medical emergencies have been prioritised as a key part of the safety and healthcare teams messaging to all staff. This is regularly communicated through posters in the gate and an updated reminder was issued in April 2022. Additionally, reminder pocket cards were produced for all staff that include the	Head of Safety HMPPS	Completed

			correct codes to be used in a medical emergency. As part of the monthly safety meeting the safety team carry out a quality assurance check to monitor response times for emergency codes to identify opportunities for learning.		
7	The Governor and Head of Healthcare should ensure that healthcare staff: •understand and follow the national guidance on transferring prisoners to hospital under the Mental Health Act; and • inform NHS England and the Ministry of Justice's Mental Health Casework Section promptly when a prisoner is assessed as needing to be transferred.	Accepted	Funding was secured for an additional dedicated post to work closely with NHS England and NHS Improvement (NHSEI) colleagues to improve quality, performance and safety, specifically in relation to transfer and remissions under the Mental Health Act. The post has been active in HMP Pentonville since December 2021. An operational template that records all referral activity and status has recently been updated to support productive delivery and flow. This template tracks the date of referral to assessment, the date of decision post assessment, the time from decision to transfer, and the number of days in total from referral to transfer. Each month a summary of all transfers concluded is provided to NHSEI. The transfer and remissions lead attends the monthly Local Delivery Board and	Transfer & Remissions Lead, BEHMHT	Completed

			regional patient safety meetings to notify HMPPS and PPG healthcare managers of any transfers that breach the 28 day timescale. In addition, there is a Psychiatric Intensive Care Unit (PICU) programme in place across London which is focused on greater collaboration between prison healthcare and PICU (commissioned as part of the acute care pathway) to enhance the patient flow within the 28 day national standard. All PICU transfers from 1 December 2021 are part of this improvement programme.		
8	The Head of Healthcare and the manager of the inpatient unit should review care plans and clinical records together to ensure that the aims and actions of the care plans are being carried out satisfactorily.	Accepted	All prisoners have a care plan and these are reviewed by a multi-disciplinary team during the weekly ward round. A routine audit to provide assurance of good care planning quality is conducted on a monthly basis by the mental health lead. The auditor will review the SystmOne records of 10 prisoners to ensure that a care plan is in place and up to date, that medication and treatment plan has been clearly recorded in the care plan, and that there is evidence that it has been discussed with the prisoner in the previous month. The results from the	Mental Health Lead BEHMHT	Ongoing

			audits completed between October - December 2021 were 100%.		
9	The Head of Healthcare and Mental Health Lead should ensure that: • there is more integrated working within the wider healthcare team; and • multi-professional complex case clinic referrals are considered for patients awaiting a mental health transfer to hospital.	Accepted	The terms of reference for the multi-professional complex case clinic (MPCCC) were rewritten in April 2021 and the clinic was implemented in May 2021. The mental health team are in attendance at these weekly meetings and all transfers are discussed. A ledger is maintained on SystmOne so that there is an audit trail of all individuals discussed in this clinic. Now that they are in post, the Transfer & Remissions Lead will be invited to the MPCCC to ensure early notification of potential referrals and reduction in clinical risk.	Medical Lead, PPG & Transfer and Remissions Lead, BEHMHT	Completed
10	The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report, including GPs and psychiatrists, and that a senior manager discusses the Ombudsman's findings with them.	Accepted	The Head of Safety has shared a copy of the report with named staff. The Head of Healthcare has shared a copy of the report with named staff.	Head of Safety HMPPS Head of Healthcare PPG	Completed