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

Ms Leona Burn at HMP Downview on 3 March 2017

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should remind all healthcare staff, including GPs, they have a responsibility to open ACCT procedures if they consider a prisoner is at risk of suicide or self-harm.	Accepted	All new healthcare staff, including GPs, now have an induction when they start working at Downview. Part of the induction covers knowing when and how to open an ACCT should there been concerns about a prisoner who is at risk of self-harm or suicide. Also, all healthcare staff are required to complete mandatory online training on ACCT and self-harm and suicide prevention in prisons. This training is renewed every year and managers have an oversight of this regularly through supervision.	Head of Healthcare Central and North West London NHS Foundation Trust	Completed
2	The Governor and Head of Healthcare should ensure that the ACCT document accompanies prisoners when they move around the prison, including to healthcare appointments.	Accepted	HMP Downview's local Suicide Prevention Policy now sets out that an open ACCT document must accompany the prisoner throughout their daily movements, including when attending healthcare appointments. This will ensure staff are made aware there is an open ACCT and enable the ACCT record to be updated in real time. Quality assurance checks are undertaken to check this is happening.	Head of Safety HMPPS	Completed
3	The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide	Accepted	Since this recommendation was made HMPPS has nationally implemented an updated version of the	Head of Safety	Completed

	and self-harm in line with national guidelines, including in particular that: • Mental health staff attend or contribute to all ACCT reviews for prisoners in their care and are fully involved in decisions about their level of risk. • A member of healthcare staff should attend all case reviews and subsequent reviews where relevant. • Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations which reflects that risk. • Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.		ACCT process known as ACCT version 6 (v6). This new version went live at HMP Downview in April 2021. One of the key principles of ACCT v6 is providing effective support through multi-disciplinary working. HMP Downview have incorporated this into their local Suicide Prevention Policy which requires all ACCT case reviews be multi-disciplinary. In line with national policy healthcare staff are always invited to attend, or provide a written contribution to the first ACCT case review and any subsequent case reviews where they are relevant to supporting the prisoner. Also, current practise sees a member of the mental health team attend the ACCT reviews for prisoners already under their care. ACCT quality assurance is conducted on every open ACCT plan at least monthly where attendance at the reviews, the assessment of risk and the setting of observations are evaluated. Complex prisoners are reviewed in weekly Safety Implementation Meetings and mental health team members attend. Mental Health staff document ACCT reviews in SystmOne patient records, and staff update risk assessments on SystmOne records as and when necessary.	HMPPS	
4	The Governor should consider initiating an investigation into the actions of SO A and Officers B and C in relation to the piece of fabric they saw in Ms Burn's room on 2 March 2017, with a view to	Accepted	In light of the thorough independent investigation already undertaken into the events of 2 March 2017 and staff actions it is not considered that a further internal investigation is required.	Governor HMPPS	Completed

	considering whether disciplinary action is appropriate.				
5	The Governor should share this report with Officer A, SO B, a senior manager and CM A and arrange for a senior manager to discuss it with them to ensure they are aware of the Ombudsman's findings.	Accepted	The report has been shared with the mentioned staff and a senior manager has discussed the findings with them. One of the members of staff has since left HMPPS and therefore it has not been possible to disclose and discuss the report with them.	Head of Safety HMPPS	Completed
6	The Governor and Head of Healthcare should ensure that nurses conducting reception health screenings always have access to the PER and have time to read it.	Accepted	All nurses conducting reception health screenings must now request to see a prisoner's PER and verify whether they are on an ACCT or have any suicide/self-harm warnings. A reminder to do this was last circulated to reception screening staff in October 2022 when a new reception screening template was piloted. Training is also provided to nurses that do reception screenings and checking the PER is part of that exercise.	Head of Healthcare Central and North West London NHS Foundation Trust	Completed