

# Action Plan in response to the PPO Report into the death of Mr James Doherty on 18/11/2021 at HMP Wormwood Scrubs

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor should ensure that all operational staff:</p> <ul style="list-style-type: none"> <li>• consider a CSIP referral when there is evidence to indicate that a prisoner may be at risk of violence; and</li> <li>• refer self-isolating prisoners to the safer custody department for discussion at the weekly safety intervention meeting, in line with the local safety policy.</li> </ul>	Accepted	<p>The national case management model for violence, the Challenge Support Intervention Plan (CSIP) is being re-launched with an expected sign off date of September 2022. Following sign off there will be consideration for further roll out of CSIP to support victims and those at risk of violence.</p> <p>A CSIP assurance model is being implemented and will feed into the monthly safety meeting so that any identified issues can be discussed and resolved.</p> <p>Since March 2022 all self-isolating prisoners are discussed at the weekly safety intervention meeting (SIM).</p>	<p>Head of Safety HMPPS</p>	September 2022
2	The Governor should review the process for sharing safety information to ensure that all prisoners identified as a risk of harm to themselves or from	Accepted	A notice to staff (NTS) was issued in January 2022 to remind staff that they must share all relevant information relating to prisoner safety, including information from intelligence reports, with the	Head of Safety and Head of Security	August 2022



	others are brought to the attention of the safer custody team.		<p>safety team. Staff briefings have also taken place to further raise staff awareness of the importance of information sharing.</p> <p>The Head of Security is currently reviewing the process for the dissemination of information between the security and safety teams.</p>	HMPPS	
3	<p>The Governor should ensure that:</p> <ul style="list-style-type: none"> <li>operational staff promptly consider a cell move when a credible risk to a prisoner's safety has been identified and record the reason if it is not considered appropriate; and</li> <li>all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.</li> </ul>	Accepted	<p>A NTS was issued in July 2022 reminding staff of the process for escalating a cell move to another wing when it is necessary but cannot be facilitated due to capacity or other operational reasons. This includes documenting the reasons for or against the cell move.</p> <p>The Head of Residence and Head of Security are undertaking a review of the process for storing wing observation books to ensure that they are archived and stored as required.</p>	<p>Head of Security and Head of Residence</p> <p>HMPPS</p>	August 2022
4	The Governor should ensure that the keyworker scheme provides meaningful and ongoing support to all prisoners in line with national policy.	Accepted	<p>Due to ongoing resourcing issues within the Band 3 officer role, HMP Wormwood Scrubs is ensuring key work is being delivered to the most vulnerable and challenging groups of men. These men have been identified as either:</p> <ul style="list-style-type: none"> <li>Prisoners at risk of suicide or self-harm (i.e. those on ACCTs)</li> </ul>	<p>Head of OMU</p> <p>HMPPS</p>	Ongoing



			<ul style="list-style-type: none"> <li>Prisoners who have been referred for Challenge, Support and intervention plans (CSIP)</li> </ul> <p>Key work is embedded within the regime management planning (RMP) and once resources allow, key work will be rolled out as per the national guidelines.</p> <p>Quality assurance processes are in place for key work to ensure that staff conduct quality interactions and that prisoners feel supported.</p>		
5	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations.	Accepted	<p>Staff responsibilities during medical emergencies have been prioritised as a key part of the safety and healthcare teams' messaging to all staff. Notices to staff are regularly re-issued to remind all staff of their responsibilities during medical emergencies.</p> <p>In March 2022 a notice to staff was re-issued in relation to carrying out a dynamic risk assessment for entering a cell in a life-threatening situation.</p> <p>Additionally, pocket reminder cards that include the correct response codes to be used in a medical emergency have been distributed to staff and are available in key locations.</p>	Head of Safety HMPPS	Completed
6	The Governor should ensure that Prison Service staff conduct an	Accepted	The guidance for informing a prisoner's next of kin was re-issued in May 2022 as face to face visits	Head of Safety	Completed



	evidence based risk assessment when deciding whether to visit a prisoner's next of kin.		<p>have resumed in line with Covid recovery planning.</p> <p>Initial contact with the next of kin following a death in custody forms part of the prison's death in custody contingency plan. It is only in exceptional circumstances, including where there may be concerns for the safety of the Family Liaison Officer (FLO), that the police would be asked to contact the next of kin. Circumstances to consider are covered in the death in custody contingency plan and all decisions are recorded in the FLO log.</p>	HMPPS	
7	<p>The Head of Healthcare should ensure that healthcare staff:</p> <ul style="list-style-type: none"> <li>• are aware of their responsibilities for escalating concerns about prisoners who refuse to collect their prescribed medication; and</li> <li>• Promptly report a disclosure of multiple NHS identities using formal reporting mechanisms.</li> </ul>	Accepted	<p>There have been multiple training sessions delivered to the healthcare team in regards to managing omitted doses. The local operating procedure (LOP) has been reviewed and shared, and any staff who are not following this process may be subject to internal disciplinary proceedings.</p> <p>The business manager will ensure that when it is identified that a patient has more than one NHS number, this is merged appropriately and in a timely manner.</p> <p>Prisoners considered at raised risk who have refused/missed medication will also now be raised at the weekly SIM.</p>	<p>Head of Healthcare</p> <p>PPG</p>	Completed



8	The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.	Accepted	The Regional Patient Safety Clinical Quality lead will deliver an education session on the lessons learnt from this death in custody with named healthcare staff.  The report will be shared and the findings discussed with the named prison staff.	Head of Healthcare PPG  Head of Safety HMPPS	August 2022
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