

## Action Plan in response to the PPO Report into the death of Mr Sebastião Lucas on 12/05/2021 at HMP Wandsworth

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:</p> <ul style="list-style-type: none"> <li>reception staff all have access to, and consider, information relevant to risk from PERs and suicide and self-harm warning forms;</li> <li>ACCT assessment interviews and the first ACCT case review are conducted separately, in line with PSI 64/2011;</li> <li>all known risk factors are considered when determining the level of risk of suicide and self-harm;</li> <li>ACCT reviews determine the required frequency of conversations with the prisoner, as well as the</li> </ul>	Accepted	<p>A new version of ACCT (v6) was rolled out nationally in July 2021 and the national ACCT quality assurance processes are now embedded at the prison. Quality assurance checks are carried out each day and learning is shared as part of the daily briefing. The quality assurance checks capture all aspects of the ACCT document including the quality of the care plan, the level of observations, and care plan actions. Any identified issues are recorded and addressed. If there are ongoing issues identified with ACCT management, there are a number of actions available ranging from additional training and support being provided up to performance management measures.</p> <p>Each day a list of ACCT reviews scheduled to take place is shared with all staff along with a list of all newly opened ACCTs. This is shared so that relevant staff such as key workers / mental health etc. are made aware and can make contact with the individual prisoner if appropriate,</p>	<p>Head of Safety HMPPS</p> <p>Head of Healthcare Oxleas NHS Foundation Trust</p>	Completed

<p>required frequency of observations;</p> <ul style="list-style-type: none"> <li>• ACCT observations take place as specified, are unpredictable and are recorded accurately;</li> <li>• all staff receive appropriate ACCT training;</li> <li>• ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk;</li> <li>• all relevant information about risk is documented in the ACCT document; and</li> <li>• staff ensure caremaps contain meaningful actions to address an individual's risks and make use of protective factors.</li> </ul>	<p>and to ensure that the required assessment and first case review are completed separately within the required timescales.</p> <p>As part of the ACCT v6 roll out, risk and triggers awareness sessions have been delivered to all staff involved in the ACCT process. This up-skilling further supports staff's ability to complete a meaningful care plan.</p> <p>ACCT reviews are held if a significant event occurs which could indicate that a prisoner is at increased risk. The decision to hold a review is a judgement call made by staff but this is also now considered as part of the quality assurance check.</p> <p>A notice to staff (NTS) is circulated on a monthly basis containing guidance on completing and recording quality ACCT observations.</p> <p>Action has been taken to amalgamate the reception and first night staffing group. This is to provide a more joined up approach for the important early days in custody and to ensure that protective measures are in place for new arrivals. Part of the first night process now includes a secondary check completed by the first night officer to ensure that any relevant risk information has been picked up and actioned,</p>	
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			<p>including adding information to the ACCT if one has been opened.</p> <p>Digital PER forms are now in use which flag risk information clearly and make it much more obvious for staff to see if a prisoner is arriving with a SASH warning form. This also aids staff to not rely solely on a prisoner's presentation.</p>		
2	<p>The Governor and Head of Healthcare should share this report with SO A, Nurse A, CM A, Officer C and CM B and discuss the Ombudsman's findings with them.</p>	Accepted	<p>The report has been shared with named staff and the Ombudsman's findings discussed.</p>	<p>Head of Safety HMPPS</p> <p>Head of Healthcare Oxleas NHSFT</p>	Completed
3	<p>The Head of Healthcare should ensure that any new information received by the mental health team from the liaison and diversion services after a prisoner has arrived at Wandsworth must inform a review of the level of risk and plan of care.</p>	Accepted	<p>New information received from the liaison and diversion services is now added to SystmOne as soon as it is received. An urgent task is then sent to the mental health team to review and assess the level of risk, including the consideration of an urgent review of the prisoner. The care plan and SystmOne records will be updated accordingly.</p>	<p>Head of Healthcare Oxleas NHSFT</p>	Completed
4	<p>The Head of Healthcare should ensure that all prisoners with multiple NHS numbers have their records merged within 24 hours of arriving at Wandsworth.</p>	Accepted	<p>All new prisoners received into HMP Wandsworth will have their summary care record checked in reception to ascertain if there are multiple NHS numbers. If more than one NHS number is identified, an alert will be placed on the SystmOne record within 24 hours of arrival and a task will be sent to the admin team to request a record merge according to guidelines</p>	<p>Head of Healthcare Oxleas NHSFT</p>	Completed

			outlined in the local operating procedure. If there are multiple NHS numbers this will be escalated to NHS Digital.		
5	The Governor and Head of Healthcare should review the Swallowed and Secreted Items Policy to include prisoners who have had illicit items taken from them and ensure any information about secreted illicit items is communicated and considered appropriately.	Accepted	<p>The Head of Security carried out a review of the policy for swallowed and secreted items and the policy was updated in February 2022 to include illicit items taken from prisoners.</p> <p>Following the review, the Head of Safety is producing guidance for staff in order to identify any potential risk linked to debts as a result of the removal of secreted illicit items.</p> <p>Whenever a prisoner is found to have secreted illicit items they are visited by the healthcare and the safety team to assess whether there is a risk or threat to the prisoner and the observation book is updated.</p>	<p>Head of Security HMPPS</p> <p>Head of Healthcare Oxleas NHSFT</p>	June 2022
6	The Governor and Head of Healthcare should ensure that accurate information is given from the scene of an emergency incident to staff in the control room about the condition of a prisoner.	Accepted	HMP Wandsworth's local communications strategy prioritises key themes, including staff responsibilities during medical emergencies, when notices are issued to all staff by safety and healthcare. A NTS was re-issued in August 2021 to remind staff of their responsibilities during medical emergencies, including the requirement to notify the control room if the prisoner is breathing or not, and the NTS continues to be re-issued on a quarterly basis. In September 2021 the communications team issued emergency response reminder cards to staff.	Head of Safety HMPPS	Completed

			Additionally, if staff do not state whether a prisoner is breathing when they use a medical emergency code, they are prompted by the control room to confirm this information.		
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