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

Mr Lukasz Lukasik on 27/05/2021 at HMP Hull

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 following a court appearance by video link: • the prisoner's NOMIS record is updated with details of the hearing and the outcome; and • staff should speak to the prisoner and consider whether the risk to themselves has changed.	Accepted	In March 2022, the Head of Operations completed a further review of the procedures that must be undertaken following a prisoner's court appearance by video link to ensure any change in risk is fully considered. All staff involved in the process have been briefed by line managers regarding the updated procedures to ensure they are aware that where there is a change in circumstance the prisoner should be taken to Reception to undergo a Reception Risk Review. Staff have also been reminded that the Visits Log Book and the prisoner's NOMIS record should be updated with the details of the hearing and the outcome. In addition, these prisoners are seen by the Reception Nurse, who carries out an interview and assesses if the risk to themselves has changed. This is recorded on SystmOne.	Head of Operations/Head of Healthcare HMPPS/CHP	Complete

2	The Governor should ensure that during a restricted regime, key work is delivered in line with the Exceptional Delivery Model.	Accepted	Since May 2022, regular key worker sessions have been reintroduced across the prison for all prisoners, in line with the original key work module. Key worker sessions are detailed on a daily basis by the wing manager and staff are briefed by the Supervising Officer. Key work key message briefings are also regularly delivered by the Offender Management Unit. The wing Custodial Manager completes a weekly 10% quality assurance check to ensure sessions have been fully recorded and meaningful interactions have taken place. The Deputy Governor has also recently commissioned a review of key work at the prison, to identify any areas where improvements can be made.	Head of Residence & Services HMPPS	September 2022
3	The Head of Healthcare should ensure that mental health staff consider the results of previous mental health assessments when completing the initial mental health assessment.	Accepted	Mental Health staff have been reminded of the importance of undertaking a thorough history check, including previous mental health assessments, communications and a check of SystmOne records, when carrying out mental health assessments. It is recognised that reading letters and communications is an essential process when undertaking checks on patients, which helps clarify diagnosis and identify medication issues. It also provides a timeline indicating the level of perceived distress and the level of support given. In addition, it can inform the practitioner if any of the interactions have been successful and whether to carry on or try new initiatives.	Head of Healthcare CHP	Complete

4	The Head of Healthcare should ensure that healthcare staff review the clinical management plans of newly arrived prisoners promptly.	Accepted	Healthcare staff have been briefed regarding the need to review the medical history of the patient, including any management plans and long-term conditions during the reception screening process. Where a need is identified the nurse will add the patient to the relevant waiting list, so that a more detailed and thorough plan of care can be put in place. This is done with the patient present, ensuring they are partners in their own care.	Head of Healthcare CHP	Complete
5	The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that: • night staff enter cells as quickly as possible in a life-threatening situation; and • night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.		All permanent night staff have been provided with training on the procedures to follow during night status. This included the importance of entering a cell as quickly as possible in the event of a life threatening situation following a dynamic risk assessment. Incidents are monitored on a daily basis as part of the Duty Governors Feedback meeting to ensure the correct procedures are being followed. Guidance is then provided where a need is identified. The Safer Prisons department have conducted morning drop-in sessions with staff regarding the correct use of the emergency codes and to reinforce the need to communicate these by radio wherever possible. All staff have also been given pocket cards that can be carried on their person, which outline the circumstances in which Code Red/Code Blue should be used so that appropriate medical assistance can be provided as quickly as possible. Posters have also been displayed around the establishment to make clear the	Head of Residence and Safety HMPPS	Complete

			requirement to call a Code Red/Code Blue should a medical emergency occur. A Governor's Order was also re-published in July 2022 to remind staff of the actions that should be taken in the event of a medical emergency.		
6	The Governor should ensure that this report is shared with staff mentioned in the report and that a senior manager discusses the Ombudsman's findings with them.	Accepted	The Head of Operations has met with both of the staff named in the report to discuss the findings and their individual roles to ensure any learning has been identified.	Head of Operations HMPPS	Complete