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

Mr Ian Davies on 06/12/2021 at HMP Bristol

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 staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff: • set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; • encourage family engagement in the ACCT process, where appropriate, to help reduce the risk of suicide and self-harm; • consider all relevant factors when assessing a prisoner's risk factors and not rely solely on their behaviour and comments when	Accepted	All ACCT case coordinators have now completed ACCT case coordinator training and a guidance document on identifying risks and triggers for suicide and self-harm has been shared with staff. The guidance document also sets out the importance of involving sources of support in the ACCT process, which could include a prisoner's family. The case coordinator has overall responsibility for discussing sources of support with prisoners and the mandatory ACCT quality assurance process includes a check that this discussion has taken place. A notice to staff (NTS) on identifying risks and triggers was issued in August 2022 and is re-issued every 16 weeks as a regular reminder to staff. Additionally, each quarter, all case coordinators are sent guidance on understanding	Head of Safety HMPPS	Completed

	deciding to stop ACCT monitoring; • arrange an ACCT review for the day a prisoner is due to return from court if they are subject to ACCT procedures and a court appearance is identified as a risk factor; • conduct ACCT observations and meaningful conversations as directed; and • complete all aspects of the ACCT document, including the morning and afternoon summaries and the daily supervisor check in the ongoing record.		risks, a quick guide for ACCT case coordinators, and defensible decision making. The safety Custodial Manager (CM) now quality assures 50% of all ACCT documents opened within a calendar month. This check includes reviewing that care plan actions are appropriate and have been signed as completed, checking that observations and conversations have been recorded, and that all aspects of the ACCT document are completed as expected. Findings from these checks are shared with the safer custody team and ACCT case coordinators to support learning and continuous improvement, with feedback and guidance given to case managers, as necessary. Quality assurance themes are also shared each month at the safety strategy meeting. The weekly safety action meeting (SAM) provides an opportunity to consider all prisoners who have an upcoming trigger date and actions are now put in place to mitigate any potential increase in risk. This includes scheduling ACCT reviews to consider whether there is an increase in risk and to ensure that the level of observations remains appropriate.		

			HMP Bristol and Avon and Wiltshire Partnership managers have a protocol for ACCT first case reviews. The mental health team attend all first case review for all ACCTs opened. The purpose of attending this review is to provide a multi-agency contribution to the ACCT process, be a single point of contact for initial healthcare concerns and assist in the development of the ACCT care plan.		
2	The Prison Group Director for Avon and South Dorset should write to the Ombudsman setting out what action is being taken to improve ACCT procedures at Bristol.	Accepted	The Prison Group Director for Avon, South Dorset and Wiltshire will review ACCT assurance and improvement processes at both a group and local level, and will then write to the Ombudsman setting out the strategy for improvement to address repeat recommendations.	Prison Group Director for Avon, South Dorset and Wiltshire HMPPS	October 2022
3	The Head of Healthcare should ensure that healthcare staff: • review prisoners' starting antidepressants in line with the Royal College of General Practitioners' guidance. • record actions and decisions about prisoners' ongoing care in their medical record and check that the entries have saved; and		Prescribers starting antidepressants will ensure that prisoners are booked in for a follow up review periodically in line with the Royal College of General Practitioners' guidance. All healthcare staff have been reminded to ensure an entry is recorded on SystmOne patient records and where there are any issues with saving records, these are escalated to the Head of Healthcare and an incident report submitted. The mental health service lead will ensure that the duty healthcare professional completes crisis visits	Head of Healthcare Avon and Wiltshire Mental Health Partnership NHS Trust	September 2022

	• conduct welfare crisis visits as soon as possible, ideally on the same day as the request.		on the same day as referral or, where this is not possible, the immediate day after.		
4	The Head of Healthcare should ensure that prisoners returning to HMP Bristol following a temporary absence are offered a medical review if they meet the criteria set out in PSI 07/2015.		The Head of Healthcare will work with the Head of Safety and Head of Operations along with the police court liaison and diversion services (PCLDS) to ensure that all prisoners returning to the prison following a temporary absence are offered a medical review if they meet the criteria set out in PSI 07/2015 including those returning from video link.	Head of Healthcare Avon and Wiltshire Mental Health Partnership NHS Trust	October 2022
5	The Head of Healthcare should ensure that Police Court Liaison and Diversion Service (PCLDS) staff forward mental health assessments and any other pertinent information about a prisoner's risk to the mental health team's central mailbox.		The Head of Healthcare has shared this recommendation with the PCLDS service manager along with the appropriate email address to send correspondence to. The Head of Healthcare has reminded the team onsite to ensure that they share the generic email address to forward relevant correspondence to rather than individual email addresses.	Head of Healthcare Avon and Wiltshire Mental Health Partnership NHS Trust	Completed
6	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	A notice to staff (NTS) was published in July 2022 setting out the expectations for opening cells alone and during the night state. This notice is reissued every 16 weeks as part of the safety communication strategy.	Head of Safety HMPPS	Completed

			All new Operational Support Grade staff (OSGs) and Officers have a safety induction. This includes a briefing on opening cells alone or at night and the need to conduct a rapid dynamic risk assessment. All staff are issued with an electronic safety guide that includes information and guidance on opening cells alone or at night. This guide is also available in the foyer area of the prison.		
7	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.		A copy of the report has been shared with all named staff and the Ombudsman's findings have been discussed. The Head of Healthcare will meet individually with the staff named in the report to discuss and share the findings. The Head of Healthcare will share recommendations with service managers to ensure any appropriate actions are implemented within the relevant services, and will share 'lessons learned' with the wider team at team meetings.	Head of Safety HMPPS Head of Healthcare Avon and Wiltshire Mental Health Partnership NHS Trust	September 2022