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

Mr Steven Hart on 29 March 2023 at HMP Bedford

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should ensure that ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk and improve the quality assurance process that confirms this learning has been embedded.	Accepted	In response to an identified need an ACCT and CSIP floorwalker has been introduced to identify needs such as increased risk. As a result, a weekly Safety performance meeting has begun to review current assurance and identify trends, feeding back this information into a daily briefing with supervisors and management grades to ensure that all risks are identified and supported at the earliest opportunity. Quality assurance across all check A check B and Check C' will be completed for 100% in conjunction with incident reporting to ensure that all risks are identified and support. Staff briefings during a safety month at HMP Bedford in June will have a focus on increased risk and appropriate actions to be taken, including the need to hold an ACCT review following an event indicating increased risk.	Head of Safety HMPPS	July 2024

2	The Governor should ensure that all information requested by the PPO following a death in custody is provided promptly.	Accepted	The Safety department has a new hub manager who has responsibility for collating the information requested by the PPO and who will be overseen by the Head of Safety. All responses will be completed in line with request and this will be monitored and relevant communication with the PPO will be made where information is delayed or unavailable.	Head of Safety HMPPS	July 2024
3	The Head of Healthcare should ensure that mental health assessments are updated when there are changes in a prisoner's clinical presentation and circumstances.	Accepted	Regular record keeping audits are occurring to ensure quality and gain assurance. A daily 'buzz' meeting ensured that all actions are completed, and the weekly team meeting provides further oversight. SystmOne is updated in response to clinical chances and the establishment is made aware of in immediate risk via the weekly SIM meeting.	Head of Healthcare Northants Healthcare NHS Foundation Trust	July 2024
4	The Head of Healthcare should ensure that a care plan is created for prisoners who are at increased risk of suicide or self-harm.	Accepted	Care plans are created in conjunction with the establishment to ensure prisoners and staff are aware of immediate risks. MDT's occur when the risk is in need of urgent intervention. The self-harm pathway now acts as a guide for healthcare partners in need of further assistance. Attendance in ACCT reviews is greatly improved but further work is required from Primary Care and Supporting Change to increase attendance.	Head of Healthcare Northants Healthcare NHS Foundation Trust	July 2024