

## Action Plan in response to the PPO Report into the death of Mr Rajwinder Singh on 25 June 2023 at HMP Wandsworth

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries.	Accepted	A dip test of ACCT checks against CCTV will be completed on one residential wing. Depending on the outcome of the dip test next steps will be agreed if so required.	Head of Safety	August 2024
2	The Governor should provide the Ombudsman with a clear plan of how she is addressing the issues identified with assessing and managing prisoners' risk of suicide and self-harm, including training and continuous improvement provision.	Accepted	<p>A new highly experienced Governing Governor has been appointed along with an additional temporary Deputy Governor for 12 months to strengthen and inject experience into the Senior Leadership Team and to provide a clear vision for improving delivery and outcomes.</p> <p>Prison Performance Support Programme (PPSP) support will be deployed to underpin longer term support for the prison. PPSP colleagues will conduct a full Requirements Analysis to identify first order issues, operational impacts, and outcomes, and will develop and support an improvement delivery plan across a 12–18-month timeframe.</p> <p>A national Standards Coaching Team will be deployed to the prison for 16 weeks from 2 June</p>	<p>Area Executive Director (AED) – London</p> <p>Improvement and Support Group (ISG)</p> <p>HMPPS</p>	July 2024

		<p>2024. This will support improved delivery standards via 'on the job' coaching and mentoring to frontline staff. The focus will be on accounting for prisoners and security awareness. It will include support for supervisors (SOs) and first line managers (CMs) as well as supporting the development of a London Coaching Team to continue to embed skills once this deployment has finished.</p> <p>The Area HR Business Partner (HRBP) Lead will establish mentoring and community of practice among middle managers across London to share best practice in this area, supported by Improvement Support Group (ISG) with a focus on sharing best practice and a sense of learning community.</p> <p>The newly launched local 'Supervising Officer Academy' will be utilised to upskill aspiring Band 4 SOs. This will enhance the development of staff confidence and capability and build upon the work of the Standards Coaching Team. The prison will implement 'speed school' training targeted at inexperienced officers and will provide local regular bitesize sessions to improve basic skills and 'jail craft'.</p> <p>Two temporary Band 4 Safety floorwalkers will be appointed for at least 12 months to build local knowledge, confidence and capability and improve practice in managing vulnerable and violent prisoners. Upskilling and support for these</p>		
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			<p>roles will be provided by the National Safety Team (NST).</p> <p>A safety summit will be scoped and prepared, supported by the National and Prison Group Safety Teams, using feedback from prisoner and staff focus groups to inform the content. The outcome of the summit will inform the prison's Safety Strategy and corresponding delivery plan.</p> <p>All prisoners identified as complex, vulnerable and at risk of harm to self or others will be individually discussed at the weekly Safety and Intervention Meeting (SIM) chaired by the Head of Safety and allocated a keyworker as a priority cohort.</p>		
3	The Governor should provide the Ombudsman with a clear plan outlining how they will improve cell bell response times.	Accepted	The importance of prompt responses to cell bells will be communicated with staff supported by the introduction of a regular covert testing programme and a system to ensure that staff prioritise the response to cell bells for those prisoners subject to Assessment, Care in Custody and Teamwork (ACCT) procedures. This will allow improved oversight and assurance and enable challenge where required. The local safety team will produce a daily response report which they will circulate to all managers in order for appropriate challenge to be undertaken where response times need improvement.	Head of residence	June 2024

4	The Head of Healthcare should ensure that the prescribers have a face-to-face conversation with a prisoner if there is an intention to reduce or cease any high risk prescribed medication.	Accepted	This process is set out within the Gabapentinoids Prescribing Flowchart and indicates the need for prescribers to see the patient to explain the reason for reducing and de-prescribing Gabapentinoids, and this is followed up by a letter to the patient. The Lead GP has reminded all prescribers of this process and an updated version of the flowchart was approved by the Medications Management Committee in June 2024, circulated with prescribers and saved on the shared drive for all staff to access. Compliance with this recommendation will be monitored within the Quality Management meeting agenda which regularly reviews evidence for our consolidated action tracker of recommendations resulting from serious incidents.	Head of Health Care	Completed
5	The Head of Healthcare should incorporate closer healthcare observations for prisoners who are on a reduction regime and/or are being taken off Gabapentinoids, to monitor withdrawal symptoms and any adverse effects.	Accepted	Prisoners who are placed on a reduction regime of Gabapentinoids will be placed on the caseload for substance misuse observations to monitor withdrawal symptoms alongside those placed on the caseload for opiate or alcohol withdrawal. This is beyond what would be put in place in the community and is in recognition that although such a reduction is in accordance with clinical guidelines and best practice, it should be recognised as a potential stress factor for prisoners within their early days in custody.	Head of Health Care	July 2024

6	The Head of Healthcare should ensure that agency staff receive an appropriate induction when they start at Wandsworth so that they are clear about the expectations of healthcare staff at the prison.	Accepted	All agency nurses receive an induction at Wandsworth which is coordinated by the Practice Development Nurse. In this case the agency nurse involved was experienced in working in prisons and was aware of the expectations of healthcare staff. Action was taken by the Head of Healthcare as soon as this incident occurred, and the nurse did not return to work at Wandsworth. The clinical review was shared with the agency in order that they could address the issues identified in a supportive manner with the agency nurse.	Head of Health Care	Completed
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