Action Plan – Mr Keith Turner at HMP Humber – Self-Inflicted death on 09/01/2020				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular understand: • the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated; and • the need to consider risk factors rather than simply relying on what the prisoner says or how he presents.	Accepted	All newly employed prison staff, including healthcare, receive Suicide and Self Harm (SASH) training, which includes awareness of ACCT procedures as part of their induction. Staff are provided with an in-depth overview of safer prisons and guidance around the opening of an ACCT, including risk identification. In addition, all healthcare staff must complete the 'Suicide Let's talk' E-learning training. To reinforce this learning and strengthen understanding around ACCT processes, including the importance of recording and sharing of information, the prison training department will organise further SASH training days with priority given to healthcare staff. A Safer Custody up-skilling plan has also been put in place, which will provide bite size refresher training for all staff, including CHCP and other non-directly employed agencies. The prison are also working towards ensuring that all healthcare staff have access to and are trained in the use of HMP IT systems, particularly NOMIS. This will allow them access to all electronic systems so that relevant risk information can be easily shared between healthcare and prison staff. It is hoped that this will be completed by the end of October 2020. Going forward access and training will be provided as part of the induction process, with monitoring undertaken to ensure this has happened. Intelligence and information regarding risk is also shared and reviewed via the daily briefing, the morning meeting, and the weekly Safety information	Head of Safety October 2020

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			meeting (SIM). All staff who work at HMP Humber, including those who are non-directly employed, have access to the daily briefing sheets which are available via the shared drive, with printed copies displayed in the main gate area every day. A manger from the healthcare team attends all morning meetings and a healthcare representative (usually from the Mental Health team) attends the weekly SIM and coordinates attendance at the daily ACCT case reviews. Locally developed key message alerts are also regularly shared with staff. In March 2020, a key message was issued reminding staff of the risk factors and triggers that should be considered when assessing the risk of suicide and self-harm. The importance of building relationships and holding regular conversations was also reiterated so that a full assessment of risk can be undertaken, rather than decisions being made on presentation alone.	
2	The Head of Healthcare should share a copy of this report with Senior Nurse A and Nurse B and discuss the Ombudsman's findings with them.	Accepted	A meeting has been held between Senior Nurse A and her line manager to discuss the report and to identify individual learning needs. Nurse B no longer works for CHCP, however is currently completing agency work within other prisons. The CHCP Ops manager will contact Nurse B and arrange a meeting so that this report can be discussed and any recommended learning needs identified.	Head of Healthcare September 2020

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3	The Head of Healthcare should ensure that: • mental health tasks are checked daily, clearly actioned and allocated to appropriate members of the team; • mental health services are prioritised and reallocated when staff leave the service; and • all staff are trained in the use of the patient health questionnaire and the generalised anxiety disorder score and they feel competent to complete them.	Accepted	Check lists of daily duties including mental health tasks have been introduced which includes the name of the person accountable for completion. Records are audited as part of the supervision process to ensure that staff are undertaking tasks and checking the system daily for new tasks and/or updates. A Duty role has been introduced to support staff sickness and reallocation of work where a member of staff leaves and there is no replacement. There is also a process in place for staff to re-allocate patients based on needs when staff have given a notice period. The Head of Healthcare is content that all mental health staff understand and are competent to complete both the patient health questionnaire and the generalised anxiety disorder score. Ongoing refresher training will be organised and scheduled. All new starters and agency staff will also be trained in these processes.	Head of Healthcare Completed
4	The Effective Practice & Service Improvement Group (EPSIG) should liaise with SSCL to ensure that any calls raising credible concerns about a prisoner should be transferred	Accepted	The Effective Practice & Service Improvement Group (EPSIG) have responsibility for maintaining oversight of SSCL performance on behalf of HMPPS. In February 2020 a protocol was agreed covering all public sector prisons that requires any call received by SSCL which raises an immediate wellbeing concern is not considered closed until a suitable person on site has been personally briefed. If the initial call to the establishment's Safer Custody hotline fails to be answered or goes to voicemail the case is	EPSIG/SSCL Completed

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	to Humber's Safer Custody hotline.		escalated by the SSCL call handler, by speaking in person to the Duty Governor or Orderly Officer. Escalation calls are also recorded separately by SSCL. EPSIG receive and assess monthly management information from SSCL that includes performance on handling all safety related calls.	
5	SCCL should provide refresher training to its switchboard staff to ensure that they know what to do when they receive calls raising concerns about a prisoner's wellbeing.	Accepted	The protocols on the handling of wellbeing calls which were revised following this incident are now part of the training for all call handlers and are included in handlers' operational instructions.	EPSIG/ SSCL Completed
6	The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	In July 2020, a Notice to Staff was issued providing staff with clear instructions regarding their responsibilities during the unlock process. This reinforces the need for staff to ensure that they are satisfied of a prisoner's wellbeing and that there is nothing that requires immediate attention. This was emailed to all staff and will continue to be issued on a quarterly basis. In February 2020, a staff briefing also took place, highlighting the learning from Mr Turner's death.	Head of Safety Completed
7	The Governor should share a copy of this report with Officer A and ensure that a senior manager discusses the	Accepted	A meeting has taken place with the named officer to discuss the report and the Ombudsman's findings.	Head of Safety Completed

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	Ombudsman's findings with him.			
8	The Governor and the Head of Healthcare should ensure that healthcare staff are responsible for managing emergency bags during medical emergencies, unless they are not available.	Accepted	The protocol for managing emergency bags has been re-issued to all healthcare staff and this will be reiterated in team briefings. Unless managing the emergency bag hinders their duties, they must remain responsible for it at all times. This will also be raised during staff supervision sessions. The Governor has initiated a schedule of assurance checks to ensure healthcare staff are adhering to management systems for emergency bags.	Head of Healthcare September 2020
9	The Governor should ensure that when staff call a medical emergency code, they promptly provide information about a prisoner's condition to the control room so that they can pass this information to the Ambulance Service.	Accepted	In July 2020, a Notice to Staff was issued providing staff with clear instruction about the process to follow when calling a medical emergency Code Red/Code Blue across the radio network. This instruction sets out the information that must be relayed to the Control Room, so that it can be passed to the Ambulance Service to ensure they can then respond appropriately and without delay. This was emailed to all staff and is issued on a quarterly basis. Emergency Response in Custody (ERIC) information pocket sized cards, which also provide clear instruction about the responsibilities of staff in the event of a medical emergency are handed out to all new staff during their induction briefings. These ERIC information cards have also been	Head of Safety Completed

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			circulated at a recent staff briefing and will continue to feature as part of further briefings. Emergency Response will also continue to be included as part of incident management training.	
10	The Governor should ensure that staff are offered appropriate support, including access to TRiM practitioners, following a death in custody or other traumatic event.	Accepted	Following all incidents an immediate debrief is held by the Duty Governor, with the main focus being to check on the welfare of staff. An attendance sheet is now in place at these debriefs and is checked by the Duty Governor and Orderly Officer to ensure all staff involved have been appropriately supported. It also records any immediate follow up actions that are required. TRIM practitioners are now available on a rota based system, similar to the staff care team. The care team support is widely encouraged at HMP Humber. The identified TRIM practitioner is responsible for follow up and review of all incidents that take place, including liaising with the Orderly Officer or Incident Manager regarding the staff involved. TRIM information leaflets were re-distributed in Feb 2020 and again in April 2020, to ensure all staff are aware of the TRIM practice and how to access it.	Head of Safety Completed

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11	The Governor should ensure that all managers follow the national instructions for dealing with a death in custody or serious incident, including that all staff directly involved in an incident complete Incident Report Forms as soon as possible.	Accepted	In September 2020, an email was circulated to all staff reminding them of the guidance contained within Chapter 12 of PSI 64/2011 setting out the actions that must be taken following a death in custody. Staff involved in the management of incidents were also reminded that they must ensure all staff directly involved in a death in custody or serious incident must complete Incident Report forms as soon as possible in line with guidance. This has also been reiterated at Safer Custody Awareness bite size training sessions.	Head of Safety Completed