Action Plan – Mr Robert Frith at HMP Berwyn – Self Inflicted Death on 14/11/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor should review the first night assessment booklet to assist staff in identifying other risk factors or triggers that could indicate risk of suicide and self harm.	Accepted	The first night assessment booklet was revised in November 2020 to incorporate a suicide and self-harm screening tool that encourages staff to consider a wider range of factors which might indicate a heightened risk of suicide or self-harm. Awareness sessions were held for reception staff in December 2020 to remind staff of the possible risk factors and triggers that should be considered and to provide guidance on using the revised booklet and the importance of doing so to identify any areas of risk during the initial assessments.	Completed Head of Safety and Head of Residence
2	The Governor should ensure that OMU staff: • make direct contact with a prisoner to explain any restrictions and to tell them when they are lifted; and • alert wing staff to the sharing of any potential bad news, so that they can manage this appropriately and provide additional support, if necessary.	Accepted	A staff briefing was developed in May 2021 and was delivered to all staff in June 2021 which explained the OMU processes in detail and highlighted the importance of sharing information directly with prisoners, wherever possible. This was also discussed separately with the OMU staff who were reminded to make direct contact with prisoners to explain any contact restrictions and to inform them when they are lifted. The staff briefing also provided guidance on the importance of alerting residential staff to any information which might increase the risk of suicide and self-harm in order for prisoners to be monitored and support to be provided, when required.	June 2021 Governing Governor and Head of OMU

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3	The Governor should ensure that: • cell conditions are properly checked and documented; • repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved; and • prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012.	Accepted	A local policy was implemented in November 2020 to provide guidance to staff on ensuring that cells meet the required standards. The policy states that staff should monitor cells during any relocations to ensure that all items within a cell are not removed, that all cell facilities are in order, and no maintenance work is required prior to the new occupant moving in. Staff were reminded during briefings in May 2021 to ensure that the pre-occupancy cell checks are completed prior to locating a prisoner within a cell. If any issues or faults are identified during the checks, these should be reported to the maintenance department immediately and documented on the maintenance database, PlanetFM. If a cell does not meet the required standard, prisoners should be relocated until the required maintenance work is completed. Staff were also reminded during the briefings of the importance of completing daily accommodation fabric checks (AFCs) of all cells and to ensure these are logged correctly and any issues are documented and reported immediately.	Completed Head of Residence
4	The Head of Healthcare should ensure that: • healthcare staff working at Berwyn have timely access to advice, support and guidance from on call healthcare managers; and	Accepted	The Death in Custody Protocol will be reviewed by September 2021 to provide guidance for healthcare staff on the advice and support that is available during out of hours and how to access the support available following involvement in significant events. A number of measures are now in place for healthcare staff to have access to the required advice, support and guidance from the on call healthcare managers which is available through the prison health management rota. The	September 2021 Head of Healthcare

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	• appropriate measures are put in place to offer support to healthcare staff following their involvement in significant incidents.		GP out of hours service also provides any required clinical support, advice and guidance and the BCUHB on call rota with initial entry at East Area bronze provides assistance for the escalation of any operational issues. Healthcare staff also have access to a number of measures which provide support following any involvement in significant incidents which include the staff debriefs which are coordinated by the prison command suite and the Care Team who provide support following this to all staff. Referrals can also be made to the BCU Occupational Health Service by staff or their managers and full access to the employee assistance programme, PAM Assist, and the Critical Incident Support services are also available. PAM Assist is a HMPPS resource available to all staff working in prisons particularly in relation to significant incidents.	