Action Plan – Mr Liridon Saliuka at HMP Belmarsh – SID on 02/01/2020				
No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor should ensure that staff understand the need to record and share relevant information that may affect a prisoner's risk.	Accepted	The establishment operates the key worker model, delivering key work sessions of up to 90 minutes within each 14 day period to all prisoners. Management checks are in place to ensure contact is being maintained and quality interactions are documented. All staff are made aware during initial key worker training that any risk information arising from sessions should be reported appropriately, either via line managers, by means of an intelligence report, or in the observation book. Residential managers use daily briefings to remind staff of the importance of documenting their engagement and interactions with prisoners. The Safer Custody team have attended briefings to promote the importance of recording and sharing relevant risk related information and nursing staff now attend handovers each morning on the house block to share any information they have which may affect a prisoner's risk. Weekly multi-disciplinary Safety Intervention Meetings (SIM) chaired by the Safer Custody team are held to discuss any prisoners of concern to ensure that all relevant parties have up to date information and to ensure that robust plans are in place to ensure wellbeing.	Head of Residence Completed
2	The Governor and Head of Healthcare should ensure that where a prisoner requires special accommodation or equipment for medical or social care reasons, this is	Accepted	When a prisoner requires special accommodation or equipment for medical or social care reasons healthcare will make a referral to the Royal Borough Greenwich (RBG) social care team who will complete an assessment. Any care plans created from the assessment are uploaded to the patient's medical records on SystmOne.	Head of Healthcare Completed

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	formally authorised and recorded.		In complex cases a multi-disciplinary team (MDT) review meeting is conducted and all agencies involved in the prisoner's care are invited. The MDT review is recorded on the prisoner's SystmOne medical records and, with the prisoners consent, GP records are also obtained.	
3	The Governor should ensure that prisoners are promptly allocated a key worker, who is able to see them on a regular basis.	Accepted	The establishment operates an auto allocation system for key workers whereby all prisoners are allocated a named key worker shortly after arrival who will meet with them within 14 days and continue to do so on a rolling programme. Additional management checks were introduced in December 2020 to ensure that all prisoners have a keyworker allocated to them within 14 days and that contact is being maintained, with quality interactions appropriately documented.	Head of Residence Completed
4	The Governor should ensure that staff regularly check and respond promptly to messages left on the Safer Custody hotline.	Accepted	Following Mr Saluika's death changes to the safer custody hotline were introduced. These changes included adding an emergency contact number to the hotline answerphone to ensure that any urgent calls will be answered outside of standard working hours. The number directs the call to the control room which is staffed 24/7. Additionally, all calls to the hotline must now be recorded on a database along with the name of the member of staff who took the call and any actions taken in response. The hotline answer phone is checked each morning for any out of hours messages and details are also added to the database. The Head of Safety reviews the database to ensure that calls have been documented correctly and appropriate actions have been taken.	Head of Safety Completed

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5	The Head of Healthcare should ensure that psychiatric and psychological assessments: • are actioned within a specific timeframe; and • are not cancelled unless there are justified and documented reasons.	Accepted	The psychiatrist is in the establishment each day and urgent psychiatric assessments are completed within 24 hours of a referral being made. Out-patient appointments take place within four to six weeks, this is assessed on an individual basis depending on the needs of each prisoner. Prisoners are contacted in writing within four weeks to advise them of the referral and to let them know that they have been added to the waiting list. Within this letter alternative support systems are signposted, such as the Samaritans, and information is given on how prisoners can contact the team whilst awaiting an appointment. Thereafter, within four to six weeks, prisoners will receive in cell intervention during the first initial face-to-face visit. If an assessment or appointment has to be cancelled or rescheduled, the reasons for this are now clearly documented on SystmOne.	Head of Healthcare Completed
6	The Head of Healthcare should ensure that all staff: • are aware of their responsibility to open an ACCT if they have concerns that a prisoner may be at risk of suicide or self-harm; and	Accepted	ACCT ‘Getting it right’ guidance has been shared with all healthcare staff and staff have now completed Oxleas e-learning suicide awareness training which reminds staff to consider all risk factors for suicide and self-harm and not to rely solely on a prisoner’s presentation. A record is kept of all staff who have completed ACCT training in order to monitor compliance. ACCT management checks are regularly conducted by residential managers and the Safer Custody team to ensure that standards are being met and any learning points are shared with case managers to improve the overall quality of the ACCT process.	Head of Healthcare Completed

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	• understand that they need to consider a prisoner's risk factors when assessing his risk of suicide or self-harm, and not focus solely on what the prisoner says about his intentions or how he presents.			
7	The Head of Healthcare should share this report with the specialist psychological therapist and discuss the Ombudsman's findings with her.	Accepted	A copy of this report has been shared and the Ombudsman's findings have been discussed.	Head of Healthcare Completed
8	The Governor should ensure that staff call a medical emergency code as soon as possible if a prisoner appears to be hanging.	Accepted	A Governor's Notice To Staff (NTS) was issued in June 2020 reminding all staff of the established medical emergency codes and when they should be used. A learning bulletin created by the national Safety team titled 'The Importance of Immediate Emergency Response' was also re-issued alongside this.	Head of Safety Completed
9	The Governor should share a copy of this report with Supervising Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.	Accepted	A copy of the report has been shared and the Ombudsman's findings have been discussed.	Head of Safety June 2021

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No	**Recommendation**	**Accepted/ Not Accepted**	**Response**	**Target date for completion and function responsible**
10	The Governor should ensure that the CCTV cameras on Houseblock 4 are reactivated or replaced as a matter of urgency.	Accepted	Funding for CCTV to be installed on house block 4 has been agreed and a start date for this project is awaited.	Governor Completed
11	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.	Accepted	Resuscitation training is being provided by Oxleas to all clinical staff. A compliance report is updated and shared with the Head of Healthcare and managers on a monthly basis. A copy of the resuscitation guidance has been shared with all prison GPs.	Head of Healthcare Completed
12	The Head of Healthcare should share a copy of this report with GP A and provide him and the prison's other GPs with a copy of the resuscitation guidance.	Accepted	A copy of this report has been shared with all prison GPs for learning and a copy of the resuscitation guidance has also been shared.	Head of Healthcare Completed
13	The Governor should ensure that a family liaison officer breaks the news of a death to a next of kin in person as soon as possible, in line with PSI 64/2011.	Accepted	Family Liaison Officers (FLO) are deployed to meet with a prisoner's family following confirmation of death and identification of the next of kin. A review of FLO procedures was carried out in March 2021 to ensure that there are an appropriate number of staff trained and available to undertake the role of FLO as required.	Head of Safety Completed

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			A list of trained FLO staff has been made available to the control room managers and Duty Governors for the purpose of identifying available staff without delay.	
14	The Governor should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody, in line with PSI 58/2010.	Accepted	A member of the Safer Custody team has been appointed as a point of contact for PPO and death in custody investigations to ensure that all requested documents can be sourced and provided in a timely manner. As part of the review of FLO procedures which was carried out in March 2021 all aspects of the role have been reviewed to ensure that staff acting in the capacity of FLO are appropriately trained and available to complete and submit reports, as required.	Head of Safety Completed
15	The Governor should ensure that after a prisoner dies, prisoners who were close to him are informed of the death personally and offered appropriate, individual support.	Accepted	In the event of a prisoner's death, all prisoners who identify or are identified by staff or other prisoners as having been close to him will be informed of the death personally. This will be done initially by residential managers and will be followed up by healthcare and chaplaincy representatives, as required. Individual and group support opportunities will be organised and facilitated by the Safer Custody team in conjunction with healthcare and the chaplaincy department and made available to all prisoners.	Head of Safety Completed