Action Plan-Sadik Duba. HMP The Mount. Self- Inflicted. 29/05/2016				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who assess risk: • Have a clear understanding of their responsibilities and the need to record relevant information about risk; • Consider and record all the known risk factors of prisoners when determining their risk of suicide or self-harm; • Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.	Accepted	The Safer Custody Policy is in the process of being significantly updated. The completed document will provide clear guidance regarding the procedure for identifying those men at risk of harming themselves or ending their own lives. It will also identify the means of support we aim to provide such as Listeners and access to Samaritans phones. The '3 Step ACCT Management Check' system was implemented in May 2017 – ensuring all activities undertaken produce high quality care and support; monitor the quality of ACCT documentation to identify areas of good practice and immediate concern; provide analysis of the individual cases, day to day support and quality of management checks to then make improvements on the level of care for prisoners in crisis. It will also assist with our continuous improvement with regards to the recording of relevant information, something we have identified as being in need of improvement. SASH (Suicide and Self-Harm) training is being rolled out for all staff who have contact with prisoners in accordance with National Guidelines and Case Manager ACCT training is ongoing. An initial needs assessment was completed in May 2017 and as a result we are particularly focusing on the triggers and the 'observations' SASH modules to ensure staff take into account risk triggers and do not rely solely on the presentation of the prisoner.	Head of Safer Prison and Equalities by June 2017
				NHS

Action Plan-Sadik Duba. HMP The Mount. Self- Inflicted. 29/05/2016				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
2	The Head of Healthcare should ensure that all healthcare staff are aware how to obtain mental health advice out of hours or at weekends, and should: • Publish a pathway/protocol to support the primary care team at weekends/out of hours; • Publish the process for escalation if they are unable to access this; • Ensure that all nurses use a simple psychiatric symptom rating scale, to support them in the clinical decision making process.		A pathway protocol is in place for the primary care team to access mental health advice at weekends and out of hours, which includes an escalation process, via the usual provision of Hertfordshire Urgent Care. At present this out of hours and weekend advice is obtained through GP level support with acute psychiatric cases taken to A&E for assessment and treatment. NHS England is to commission an expanded service to deliver an acute on site provision. Since June 2016 all nurses have had access to the Brief Psychiatric Ratings Scale evaluation tool to help them make clinical decisions.	England September 2017 Healthcare Manager Complete
3	The Governor and Head of Healthcare should ensure that staff use the appropriate medical emergency code when a prisoner's condition is life threatening so that control room staff call an ambulance immediately.	Accepted	Staff instructions have been reissued and staff reminded through Staff Information Notices in 2016 and 2017, the last being on 23 February 2017 to remind staff of the correct procedures and their responsibilities to use the correct emergency code Control room staff are following these procedures. Since these reminders have been reissued, the correct procedures have been routinely followed in subsequent incidents.	Head of Safer Prison and Equalities Complete