Action Plan – Paul James. HMP Elmley. Self- Inflicted. 20/12/2016.				
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**
1	The Governor and Head of Healthcare should ensure that prison staff assess and manage prisoners at risk of suicide or self-harm in line with national guidelines, including holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.	Accepted	A previously published Notice to Staff will be re-issued reminding staff of the importance of ensuring Case Reviews are appropriately attended. When attendance cannot be achieved written contributions should be made. Case Reviews must be multi-disciplinary. All staff, including partner agencies are currently undergoing the new Suicide and Self Harm (SASH) training. In addition, the ACCT Case Manager training has been prioritised for all Supervisory Officers and Custodial Managers. Safer Custody will produce and publish an Aide Memoire, summarising ACCT management processes for all staff.	Aug 2017 Head of Safer Custody Aug 2019 Head of Business Assurance Sept 2017 Head of Safer Custody
2	The Governor should remind night duty staff of their responsibility to complete the night patrol reports and ensure that they do so.	Accepted	A notice to staff will be issued reminding Night Orderly officers that is their responsibility to brief night staff upon commencing duty of the requirement to complete night patrol reports. These are checked in the morning prior to release from duty by the orderly officer and checked by the Duty Governor. The Local Security Strategy will be amended to include the responsibilities of the night orderly officer and all night staff regarding patrols.	July 2017 Deputy Governor September 17 Head of Security
3	The Governor should ensure that staff satisfy themselves of a prisoner's safety at night, and if they cannot see them	Accepted	A Notice to Staff will be issued giving instructions to Night Patrols that they must raise any concerns they have about a prisoner to the Orderly Officer.	Aug 2017 Head of Safer

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	properly at checks, they use the cell night light and/or torch and tell their manager if they are concerned		The Local Security Strategy will also be amended and republished to reflect this. In this case the member of staff in this case did not use the torch issued to him. This has been addressed through advice and guidance following a Disciplinary investigation. Torches are issued to night patrols on commencement of duty. These are signed for and returned at end of duty.	Custody September 2017 Head of Security
4	The Governor should ensure that cell night lights are in good working order at all times	Accepted	Staff on all Residential areas check the functionality of all cell lights as part of the Accommodation Fabric Checks. Faults are reported immediately through the Estates Contract for repair. If the night light becomes faulty during the night, the prisoner will be moved to an alternative cell. All night staff are issued torches and replacement batteries are available. The LSS will be amended to reflect the process for the event of a night light failure Estates Contractors have been reminded about the need to prioritise the repair of all issues with cells. The monitoring of those cells with highlighted repair needs are conducted weekly.	Aug 2017 Deputy Governor Head of Security September 2017

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5	The Head of Healthcare should ensure that in the event that mental health staff are unable to attend a prisoner's mental health review, it is covered by a member of the mental health team or rescheduled promptly, and the change is recorded.	Accepted	It is important for sites with multiple Healthcare contracts to ensure that the action is directed at the appropriate specialism as the Head of Primary Care in this case has no authority over Mental Health Inreach Services. The Mental Health In-reach Team (MHIT) have a system in place if staff are unable to attend MH reviews due to absence. It is routine practice for staff to provide a handover. In the event of planned absence, the allocated worker will inform each of the patients and arrange an identified member of staff to cover their caseload following a through handover. Where an absence is unplanned, -the duty worker will hold a list of patients under the staffs caseload and follow ups will be arranged in accordance with identified clinical need. A letter is sent to the patient informing them that their allocated worker is sick. The patient is advised how to contact Mental Health Inreach Team and are reminded of support services available within the prison. If a patient be identified as high risk/need then the patient is temporarily reassigned to another practitioner The Mental Health team manager now reinforces the above processes at each daily handover briefing.	Aug 2017 MHIT Manager

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