

**Additional documents:**

1. Prison Service Action Plan

**Action Plan- Mark Doyle. HMP Pentonville. Self - Inflicted. 28/03/2017**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> <li>• Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors and set a level of observations that reflects that risk.</li> <li>• ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk.</li> <li>• A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.</li> <li>• ACCT reviews are multidisciplinary and involve all staff who can contribute to the care of a prisoner at risk.</li> <li>• A case manager is appointed at the first case review.</li> <li>• ACCT care map actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for him.</li> <li>• ACCT case managers should consider</li> </ul>	Accepted	<p>Supervising Officers have all now received ACCT Case Manager training, which reminds them of the need to consider all available information on risk, and also to adequately detail the reasoning behind changes, particularly reductions, in the level of observations to ensure that appropriate decisions are clearly documented.</p> <p>The Case Manager training also covers the need to ensure that Case Managers are identified at the first case review and that this is properly recorded, and is further developing staffs' skills in respect of the setting of caremap actions, further reinforced by a series of monthly Case Manager seminars currently being run. In addition all staff will have completed SASH training by April 2019.</p> <p>A Governor's Order was issued in December 2017, instructing staff on the need to ensure that where they are aware of an event which could mean a prisoner may be at increased risk, and particularly where they are submitting an Incident Report about self-harm, they must ensure this is also recorded in an open ACCT document and alert Case Managers/SO to the potential heightened risk.</p> <p>In August 2017, an ACCT Quality Assurance process was introduced which is driving improvements in multi-disciplinary contributions to case reviews, and the SASH and Case</p>	Head of Safer Custody Completed

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	involving the prisoner's family in the ACCT process when appropriate and record this in the ACCT plan.		<p>Manager training being delivered is also reinforcing the importance of the multi-disciplinary approach. Additionally, healthcare providers introduced a new operating procedure in November 2017 to ensure healthcare attendance at all first case reviews.</p> <p>The ACCT Quality Assurance process is also helping prompt greater consideration of engaging family members in the care and support for prisoner who are at risk (when the person at risk gives consent to such action). This issue will also form the basis for one the monthly Case Manager Seminars.</p>	
2	The Head of Healthcare should ensure that mental health referrals consider all relevant risk information to allow comprehensive and appropriately prioritised assessments.	Accepted	<p>All referrals received by the mental health team are screened at a triage meeting to ensure that those identified as high risk are seen in correct timeframe.</p> <p>New templates were designed and introduced in December 2017 which will also assist with the screening process in reception and enable for the correct referral pathway/signposting to begin at the point of entry to the prison.</p>	<p>Head of Healthcare and Service Manager for Mental Health services</p> <p>Completed</p>
3	The Governor should ensure that staff report faulty cell bells and they are checked daily in line with PSO 5900.	Accepted.	Wing managers will be reminded of the requirements of PSO 5900 through briefings held in February 2018.	Head of Safer Custody February 2018
4	The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and	Accepted	All new healthcare staff joining the service go through an induction programme where the PSI 03/2013 is discussed. All staff are also given a small type credit card to carry round with	Head of Healthcare

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	understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.		them to remind them of the correct Code Red/Code Blue calling system.  Guidance relating to the need to call an ambulance immediately when a Code Red or Code Blue is called was re-issued to control room staff in October 2017.	Head of Operations Completed
5	The Governor should ensure that the police are notified following a death in custody	Accepted	A guidance note for Orderly Officers and Duty Governors will be produced to remind them that the police must always be informed of a death in custody, even when this takes place in hospital.	Head of Safer Custody January 2018
6	The Prisons Group Director for London and Thames Valley should commission a review on the operation and management of the ACCT process at HMP Pentonville. As part of this review, he should, in particular, assure himself that HMP Pentonville has effectively implemented all PPO recommendations following self-inflicted deaths at the prison in the last five years and provide a report to me outlining progress within 3 months of receiving this report	Accepted	Following receipt of the initial report, the Prison Group Director for London and Thames Valley commissioned a review of the ACCT procedures at HMP Pentonville. This work is being carried out by the Regional Safer Custody team and will report in due course.	Regional Safer Custody lead April 2018