

Action Plan: Marcin Mazurek at HMP Garth on 08/08/15

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected</p>	Accepted	<p>A revised Violence Reduction strategy sets out the Safer Custody department's responsibility for investigating all acts of violence. This includes monitoring, co-ordinating and investigating all information indicating violence, bullying, and intimidation. The new strategy also introduces a safer custody referral that allows staff, prisoners and visitors the option of reporting acts of bullying and Intimidation.</p> <p>The strategy will include the sharing of information across the whole prison, promoting good practice, highlighting areas of concern and recommending actions to be taken, and ensuring appropriate support is provided for victims and relevant actions taken against identified perpetrators.</p>	<p>30 April 2016</p> <p>Governor Head of Safer Prisons and Equalities</p>
2	<p>The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular that:</p> <ul style="list-style-type: none"> ▪ Prisoners assessed as at risk of suicide or self-harm are not segregated unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances. ▪ Segregated prisoners assessed at risk of 	Accepted	<p>A new strategy sets out the local procedures to be followed when considering locating a prisoner subject to ACCT on the Segregation Unit or when an ACCT is opened for a prisoner located in the Segregation Unit. This will occur only in exceptional circumstances and when all other options have been tried or are considered inappropriate. The decision to locate on the Segregation Unit will be fully documented in the ACCT document, and the authorising Senior Manager will complete an exceptional circumstances authority form in all cases.</p> <p>A full mental health assessment will take place within 24 hours of a prisoner on an ACCT arriving in the Segregation Unit. A senior</p>	<p>30 June 2016</p> <p>Governor Head of Healthcare Head of Safer Prisons and Equalities</p>

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	<p>suicide and self-harm have an urgent mental health assessment within 24 hours</p> <p>There is a multidisciplinary approach for all case reviews, with healthcare staff attending all first case reviews</p> <ul style="list-style-type: none"> ▪ Caremap actions, are specific, meaningful and time bound, aimed at reducing prisoners' risks and reviewed and updated as necessary. ▪ Staff re-open an ACCT when a prisoner self-harms or otherwise indicates increased risk. ▪ ACCT case managers attend segregation reviews 		<p>mental health practitioner will take responsibility for every prisoner who enters the Segregation Unit and work closely with staff to provide guidance on working with prisoners with mental illness and increased risk of self-harm and suicide.</p> <p>All case reviews for prisoners on an ACCT in the Segregation Unit will be multidisciplinary and will put in place a comprehensive management and care plan that outlines the individual risks and needs and strategies for addressing them.</p> <p>A revised system for managing ACCT case reviews has been introduced which involves a timetable being published weekly. All relevant areas are encouraged to attend or submit verbal or written contributions where they are unable to do so. It is now mandatory at HMP Garth that mental health attends all reviews; in the rare event they are not available (i.e. out of hours) a full multidisciplinary review is held within 24 hours.</p> <p>The quality assurance process now ensures that a manager checks all ACCTS in the establishment weekly. One of the specific areas checked is the effectiveness and achievability of caremaps. Feedback is given to case managers and followed up by the Safer Custody department to ensure compliance. A league table is published monthly, showing areas managing ACCTs well and areas that require improvement.</p> <p>All staff have been reminded of their responsibilities when a prisoner self-harms. A quick time learning bulletin will be published with further guidance about what to do when a prisoner who was</p>	

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			<p>previously on an ACCT self-harms during the post closure period.</p> <p>The Segregation Unit Manager has now been identified as the named case manager for all prisoners subject to ACCT procedures in segregation, and will attend segregation reviews. Where the Case Manager is unavailable the Segregation Unit Supervising Officer will deputise.</p>	
3	<p>The Governor and Head of Healthcare should ensure that prisoners held in segregated conditions are managed under the provisions and safeguards of PSO 1700, including setting an appropriate frequency of checks, that a member of healthcare staff checks segregated prisoners daily and records this, and that there are care plans for prisoners segregated for more than 30 days</p>	Accepted	<p>The overspill area on D wing has been closed and all prisoners subject to segregation are now located in the CSU. Compliance with PSO 1700 is maintained by the segregation unit manager and monitored at the Segregation Monitoring and Review Group meetings.</p> <p>We will review our segregation risk assessment and include a section for frequency of observations on the revised form, to be completed by the Segregation Unit Supervising Officer and authorised by the Duty Governor.</p> <p>A protocol will be introduced to ensure that the Governor and healthcare and chaplaincy staff record their contact with prisoners on an ACCT located in the CSU. Compliance with this will be monitored through quality assurance checks co-ordinated by the Safer Custody department.</p> <p>Healthcare practitioners are required to record their daily contact with prisoners located in the CSU on the prisoner's clinical records on SystemOne</p>	<p>30 June 2016</p> <p>Governor Head of Healthcare Head of Safer Prisons and Equalities</p>

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			For any prisoner segregated for over 30 days a reintegration and care plan will be put in place. A formal review will take place which will be attended by the segregation unit manager and a manager from the allocated residential unit, along with representatives from the mental health team, chaplaincy and Safer Custody department.	
4	The Head of Healthcare should ensure that referrals to the mental health team for prisoners assessed as at risk of suicide and self-harm are actioned promptly and that assessments include plans to mitigate their risk.	Accepted	<p>A single point of access referral form is now available for all staff to use if they are concerned about a prisoner's mental health.</p> <p>The form is scanned on to the prisoner's record. It is discussed at the weekly single point of assessment meeting, attended by all mental health practitioners, at which the prisoner's mental state and risk is considered and they are allocated to a practitioner's caseload. The practitioner sees the prisoner promptly and develops an action plan of support to mitigate the prisoner's risk.</p>	<p>30June2016</p> <p>Head of Healthcare</p>
5	The Governor should ensure that the control room calls an ambulance as soon as an emergency medical code is called.	Accepted	The strategy for response to medical emergencies has been reissued. Where a member of staff requests medical assistance by issuing a Code Blue or Red via radio or phone, the control room will immediately request an ambulance in line with the working agreement with the ambulance service.	<p>April 2016</p> <p>Safer Prisons and Equalities</p>
6	The Governor should ensure that when a prisoner dies, a member of Prison Service staff informs the next of kin in person if possible and without undue delay.	Accepted	The contingency plans have been reviewed and tested in a desk top exercise. They include specific actions to appoint a Family Liaison Officer person following the death of a prisoner, and for them to notify the next of kin in without delay, and in person when it is possible and safe to do so.	<p>30 April 2016</p> <p>Governor Head of Safer Prisons and</p>

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